

02696

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		d. STREET ADDRESS 309 CECELIA ST.	
3. NAME OF DECEASED (Type or print) First CLARA Middle Ettie Last AGER		4. DATE OF DEATH Month MARCH Day 14 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 15, 1881
9a. AGE (In years and birthday) 79 yrs.		9b. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) OLDTOWN, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tolbert STALLINGS		14. MOTHER'S MAIDEN NAME Mary E. STALLINGS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis & Decompensation 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Asthenic & collapsed DUE TO (c) Vertebral			INTERVAL BETWEEN ONSET AND DEATH 3 mon
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 5, 1960 to Mar 14, 1960 that (I) (we) lost saw the deceased alive on Mar 14, 1960 , and that death occurred 2:50 PM from the causes and on the date stated above.			
22a. SIGNATURE Clayton L. Durrett		22b. DATE SIGNED 3/15/60	
22c. PHYSICIAN'S NAME (Type) DR. DURRETT		22d. ADDRESS 236 Va. Ave. Cumberland Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/16/60	23c. NAME OF CEMETERY OR CREMATORY Mount Olive Cem.	23d. LOCATION (City, town, or county) (State) Nr. Oldtown, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		25a. REC'D BY REGISTRAR DATE MAR 17 '60	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hunt	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2712 CERTIFICATE OF DEATH

02697

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD CO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CORA BELL APPLING				4. DATE OF DEATH Month Day Year MARCH 21 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 4	
9. AGE (In years at birthday) yrs. 64		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOSEPH DIVELBLISS			
14. MOTHER'S MAIDEN NAME BELLE GASSIE Belle Deneen				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 584X DUE TO Bacteriemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Septicemia complicated by terminal uremia DUE TO uremia (c) nausea				INTERVAL BETWEEN ONSET AND DEATH approx. 2 wks. approx 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 13, 1960 to March 21, 1960 , that (I) (we) last saw the deceased alive on March 21, 1960 , and that death occurred at 10:25 PM the causes and on the date stated above.							
22a. SIGNATURE DR. JOHN TOPPER				22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) DR. JOHN TOPPER				22d. ADDRESS HYNDMAN, PENNA.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 24, 1960		23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		23d. LOCATION (City, town, or county) (State) Hyndman, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Leigler				25a. REC'D BY REGISTRAR DATE MAR 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2713

CERTIFICATE OF DEATH

02698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 16 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First TONY Middle F. Last BARB				4. DATE OF DEATH Month 3 Day 19 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-25-56	
9. AGE (In years last birthday) 3 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME MARLIN H. Barb			
14. MOTHER'S MAIDEN NAME LOUISE WALKER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. None				INFORMANT PT'S CHART Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 500x Acute fulminating Tracheobronchitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 18 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 3-18 , 19 60 , to 3-19 , 19 60 that I last saw the deceased alive on 3-19 , 19 60 , and that death occurred at 7:05 A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED 3-21-60			
ACTUAL SIGNATURE William P. James M.D.				PHYSICIAN'S NAME (Type) WILLIAM P. JAMES, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-21-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cem.	
22d. LOCATION (City, town, or county) (State) Near Cumberland, Maryland				23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md			
24a. RECEIVED BY REGISTRAR MAR 23 60				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02699

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Bedford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>3 hours</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital Memorial&Warwick Aves.</u>				d. STREET ADDRESS <u>Hyndman</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles E.</u> Middle <u>Barnes</u> Last <u></u>				4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1917</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Celanese Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese</u>		11. BIRTHPLACE (State or foreign country) <u>Berlin, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Virgie Schilling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII Army</u>				16. SOCIAL SECURITY NO. <u>208-09-1879</u>			
17. INFORMANT <u>Mrs. Mary Barnes, Hyndman, Pa.</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion with Myocardial infarction, left, old; Coronary thrombosis right, recent</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.1</u> DUE TO (c) <u>Sclerosis and thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs (?)</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitaralic</u>				DATE SIGNED <u>March 29, 1960</u>			
EXAMINER'S NAME (Type) <u>Benedict Skitaralic, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 2, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lybarger Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Buffalo Mills, Pa. RD#1</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Keigler</u>				ADDRESS <u>Hyndman, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 1 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Clinton L. Howard</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>D.C.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage,</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>New Row</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>C.</u> Last <u>Barrett</u>							
4. DATE OF DEATH Month <u>March</u> Day <u>5th</u> , Year <u>19 60</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>April 5th, 1905</u>							
9. AGE (In years last birthday) <u>54 55</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>5</u> Min. <u>55</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed Clerk Confett.Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>			
13. FATHER'S NAME <u>James Barrett</u>				14. MOTHER'S MAIDEN NAME <u>Mary V. Lucky</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>212-10-9123</u>		17. INFORMANT <u>Mrs. Arthur Walsh, Mt. Savage, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitaralic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitaralic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>March 5, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. O'Connell</u>		ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 8 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>				24c. (City or town) (County) (State)			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

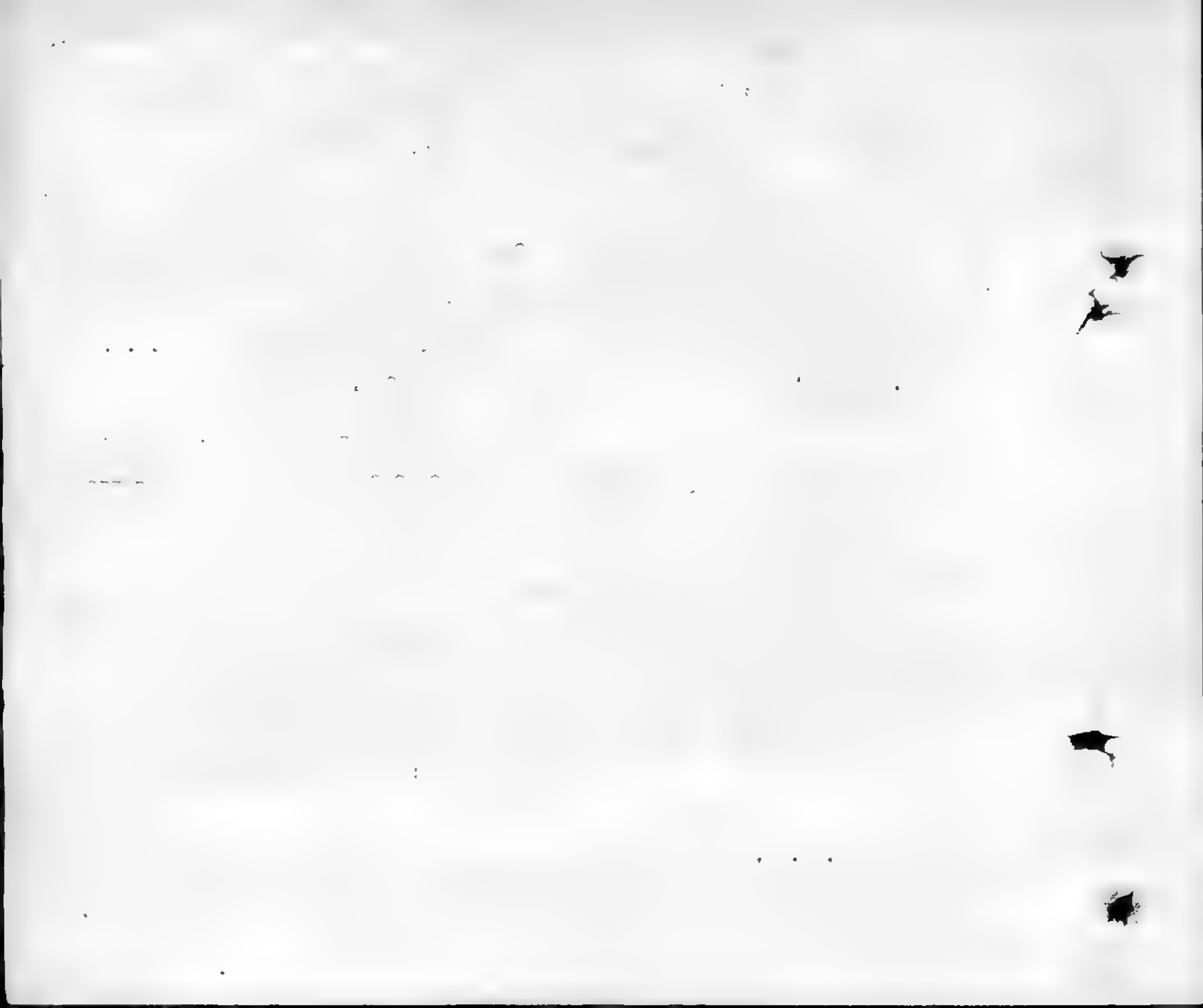
FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

may be retained by the hospital or attending physician.
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health for to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2716 **CERTIFICATE OF DEATH**

02701

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last BATESON		4. DATE OF DEATH Month MARCH Day 4 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 2, 1960
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR: Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DON C. BATESON		14. MOTHER'S MAIDEN NAME PHYLLIS D. FOX	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ENDOCARDIAL FIBROELASTOSIS 754.4 DUE TO CONGENITAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 18:40 AM 19 60 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 5:20 AM , from the causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i> M D		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. F. W. WHITWORTH		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/5/60	
23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City, town or county) (State) Westernport M.D.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		25a. REC'D BY REGISTRAR MAR 9 '60	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25c. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



2717

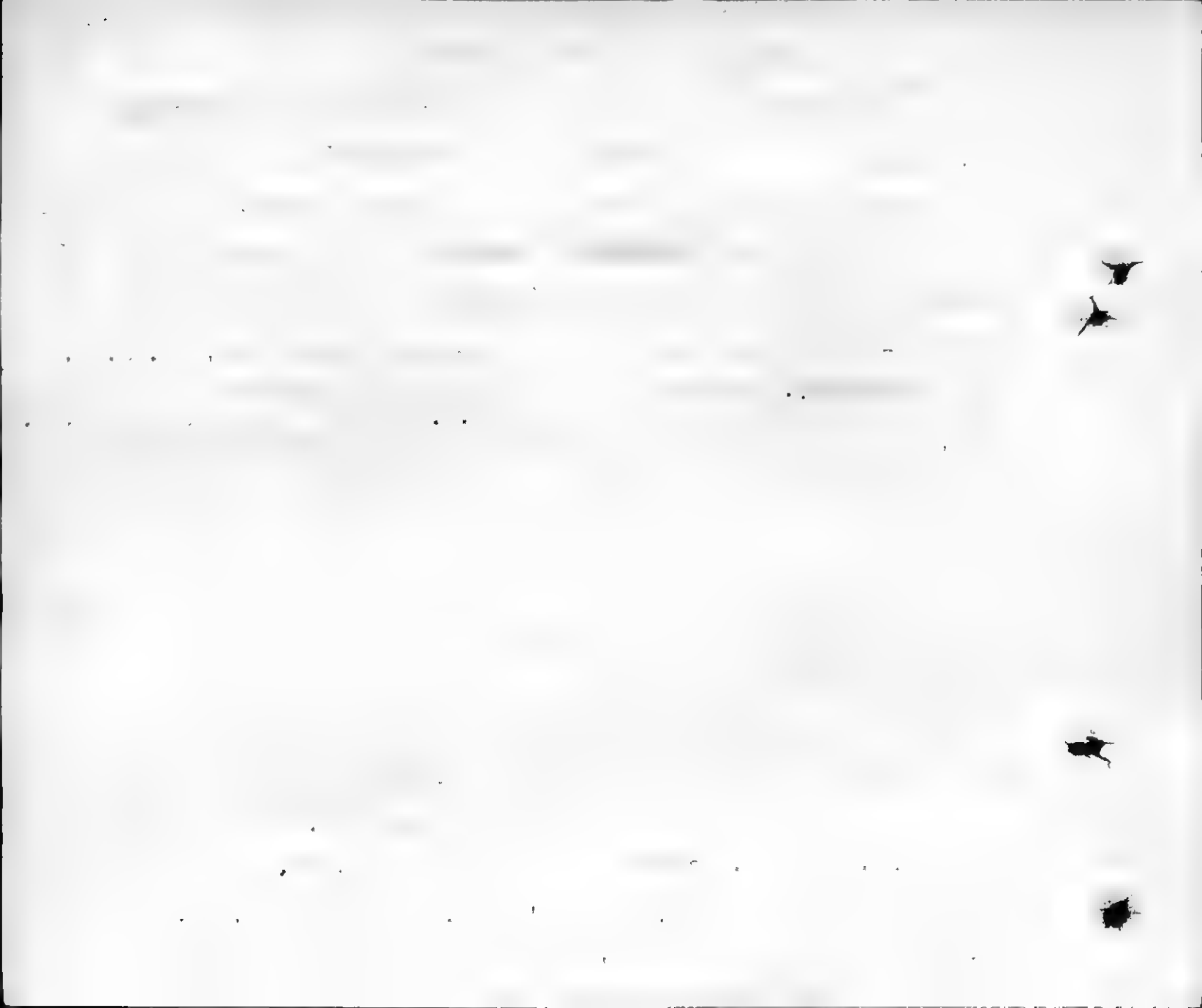
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4/19/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Margaret Last Beachy		4. DATE OF DEATH Month March Day 2 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/4/1880
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Dressmaker Ladies dress		10b. KIND OF BUSINESS OR INDUSTRY shop	
11. BIRTHPLACE (State or foreign country) Maryland, Cumberland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Francis P. Naughton		14. MOTHER'S MAIDEN NAME Sarah Louise Mickel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 219-14-6801	
INFORMANT P.O. Box 599, Address Cumberland, Md.		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 51.5x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/19/58 , 19____, to 3/2/60 , 19____, that I last saw the deceased alive on 3/1/60 , 19____, and that death occurred at 1:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 3/2/60			
ACTUAL SIGNATURE James E. McLean M.D.		PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/60	
22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Maryland		24a. REC'D BY REGISTRAR MAR 7 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Knaus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2718

CERTIFICATE OF DEATH

Reg. Dist. No.

02704

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b X Cumberland, Rt. 5,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle J. Beckman Last 		4. DATE OF DEATH Month March Day 8 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bartender		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Maryland, Cumberland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eckhart Beckman		14. MOTHER'S MAIDEN NAME Katherine Meister	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO (If yes, give war or dates of service) 214-07-1191	
17. INFORMANT Pts. Chart		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gangrene Right leg 4-22-1 DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Myocarditis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from 3-8-60 to 3-8-60 that I last saw the deceased alive on 3-8-60 and that death occurred at 5:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. T. Johnson, Jr.		DATE SIGNED 16 Greene St. Cumberland Md 3/8/60	
PHYSICIAN'S NAME (Type) J. T. Johnson, Jr.		Address 16 Greene St. Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/11/60	22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REGISTERED MAR 11 1960	
24b. REGISTRAR'S SIGNATURE John J. Hafer		DATE 	

הנהגות ודרכים אשר יצאו מן המלך
המלך המשיח ויהיה המלך המשיח
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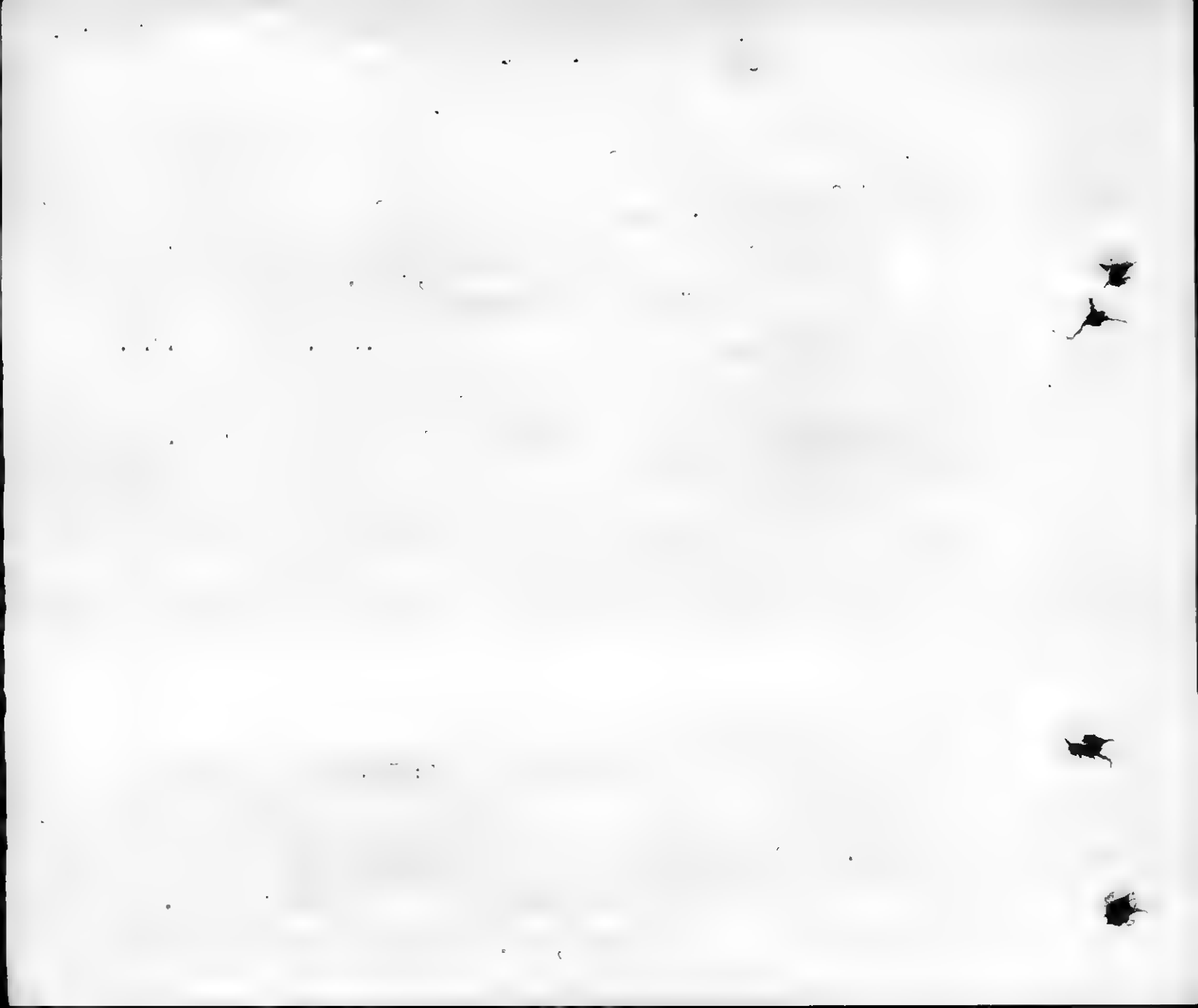
הנהגות ודרכים אשר יצאו מן המלך
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המלך המשיח ויהיה המלך המשיח

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2719 CERTIFICATE OF DEATH

02705

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 5 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS ISLAND STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JESSE Middle Last BEEMAN				4. DATE OF DEATH Month MARCH Day 16 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV, 28th. *JANUARY 1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer				10b. KIND OF BUSINESS OR INDUSTRY GARRETT CO., MD.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME DAVID BEEMAN				14. MOTHER'S MAIDEN NAME ELIZABETH CROWE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decomposition 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Cardiac Vascular Disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 11:00am 1960 to 1:00pm 1960 that (I) (we) last saw the deceased alive on 16 Mar 1960 , and that death occurred at 3:05 PM from the causes and on the date stated above.							
22a. SIGNATURE James E. Stegmaier				22b. DATE 18 Mar 60			
22c. PHYSICIAN'S NAME (Type) DR. JAMES STEGMAIER				22d. ADDRESS 122 So Centre St Cumberland, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/19/1960		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				ADDRESS LONA CONING, MD.		25a. REC'D BY REGISTRAR DATE MAR 21 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health for use in the event of a need to burial, cremation, or removal, and in any event within 72 hours after death.

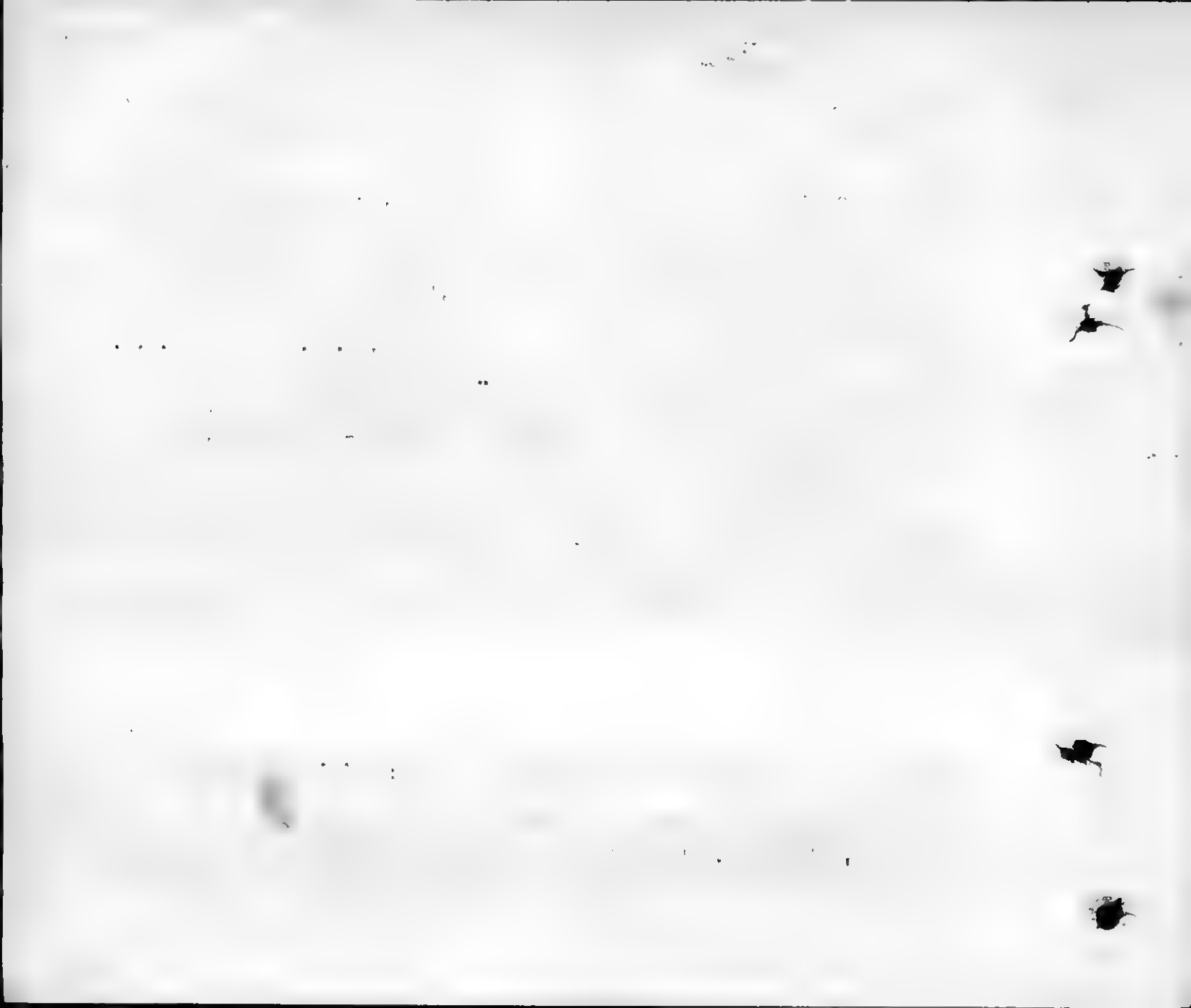


VR AIS (4)
ISM 9/59

02706

2720

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS ROUTE #4, OLDTOWN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDNA Middle BRENT Last BOXELL				4. DATE OF DEATH Month MARCH Day 17 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 28, 1896	
				9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MAGNOLIA, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN ROCKWELL				14. MOTHER'S MAIDEN NAME MARGARET HOLLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) --							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 5
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) --					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/28/57 to 4:55 p.m. 3/17/60 , that (I) (we) last saw the deceased alive on 3/17/60 , and that death occurred at 11:30 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Richard J. Williams				22b. DATE SIGNED 3/18/60			
22c. PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS				22d. ADDRESS Cumberland, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-20-1960		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR MAR 22 '60		25b. REGISTRAR'S SIGNATURE William S. Kraw	



2721

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hosp.		e. STREET ADDRESS 1135 Braddock Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle EILEEN Last BROCK		4. DATE OF DEATH Month March Day 8 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1902
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Case worker		10b. KIND OF BUSINESS OR INDUSTRY Welfare Agency	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Omar Brock		14. MOTHER'S MAIDEN NAME Mary A. Boulet	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO 215-36-8872	
17. INFORMANT Mrs. Allister Somerville, Hemmingford,		Address Quebec, Canada	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage (Subarachnoid) 350 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/24/60 , 19____, to 3/8/60 , 19____, that I last saw the deceased alive on 3/8/ , 19____, and that death occurred at 10:40 A. , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. M. Schindler		ADDRESS (Street, city or town, state) 43 Greene St., DATE SIGNED 3/9/60	
PHYSICIAN'S NAME (Type) Dr. B. M. Schindler		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/60	
22c. NAME OF CEMETERY OR CREMATORY Glen Sutton Cemetery		22d. LOCATION (City, town, or county) (State) Glen Sutton, Quebec, Canada	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR DATE MAR 14 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card on pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after date of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

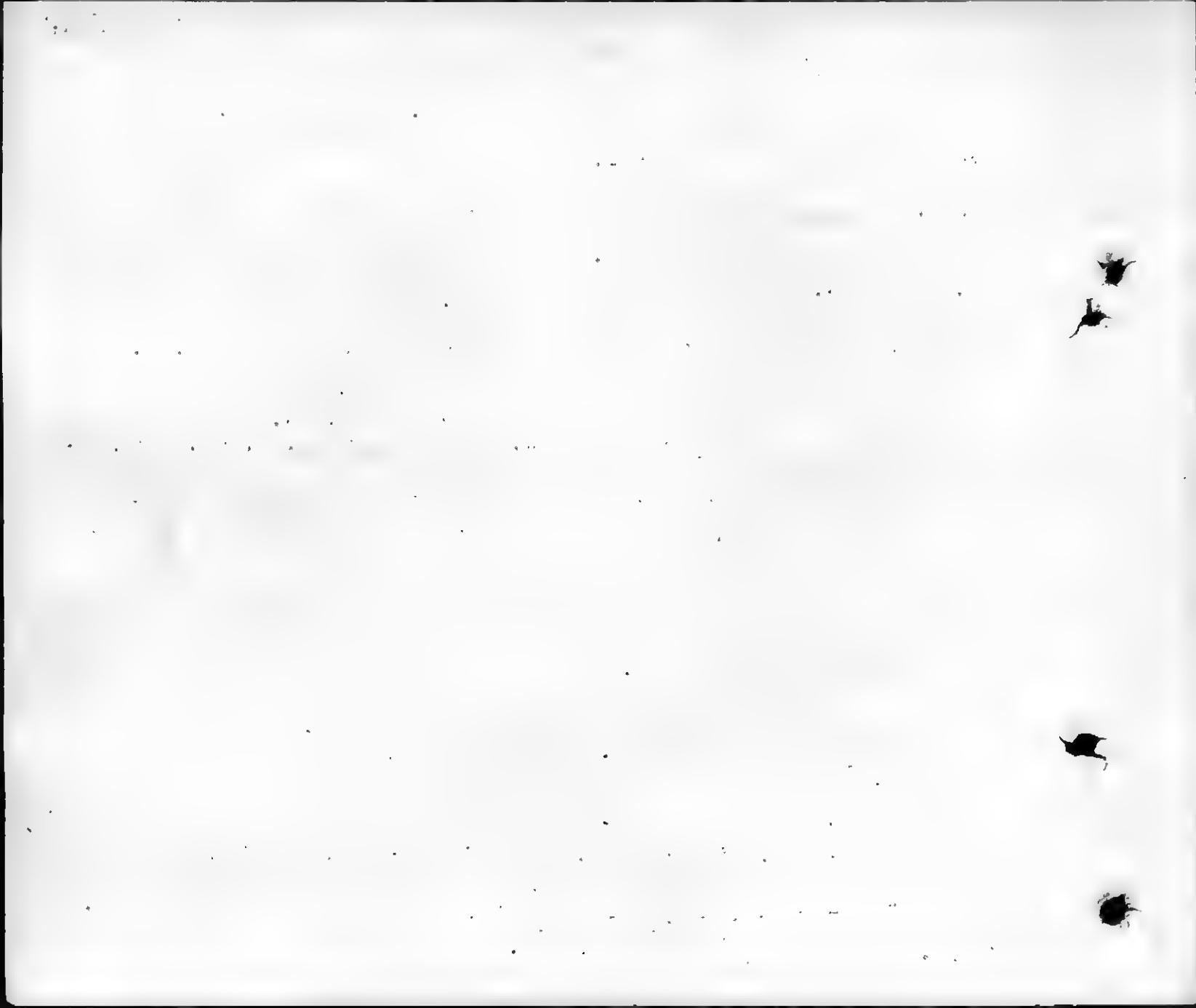
02708

2792

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b 60 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. No 2, Box 384		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frostburg d. STREET ADDRESS R. D. No 2, Box 384 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harriet Middle M. Last Brode		4. DATE OF DEATH Month 3 Day 22 Year 1960	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9 1886
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months 7 Days 3 Hours 19 Min. 60	11. IF UNDER 24 HRS Months 7 Days 3 Hours 19 Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Eckhart, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Krause		14. MOTHER'S MAIDEN NAME Margaret Leas Strube	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Frostburg, Md. Address Mrs. Geo. Griffith, R. D. No. 2, Box 384	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 433.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frostburg, Alleg. Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/28/52 , 19___, to 3/22/60 , 19___, that I last saw the deceased alive on 3/20/60 , 19___, and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 3/24/60 ACTUAL SIGNATURE Richard J. Williams, M.D. PHYSICIAN'S NAME (Type) Richard J. Williams, M.D. Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3-25-60	
22c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		22d. LOCATION (City, town, or county) Sharon Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Dean D. Mattingly		24a. REC'D BY REGISTRAR DATE MAR 28 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from page 1 and 2 should be filed with the State Board of Health for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02709

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL WILKINSON & MEMORIAL AVENUES		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THERESA Middle BRODE Last BRODE		4. DATE OF DEATH Month MARCH Day 13 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1892 9. AGE (In years last birthday) February 25, 1892 68 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Bucks CO., PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WINFIELD SCHMUTZ		14. MOTHER'S MAIDEN NAME IDA CONSTANTINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT CUMBERLAND, MD. MEMORIAL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericardial tamponade 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Ruptured myocardium - left ventricle DUE TO (c) Myocardial Infarction, acute, anterior			INTERVAL BETWEEN ONSET AND DEATH Instantly Instantly 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1948 to 3/13 19 60 , that (I) (we) last saw the deceased alive on 3/13 19 60 , and that death occurred at 5:02 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Alvessman		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. S. G. Weisman		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3/16/60	23c. NAME OF CEMETERY OR CREMATORY St Peter & Paul Cem.	23d. LOCATION (City, town, or county) (State) Cumberland MD
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		25. REC'D BY REGISTRAR DATE MAR 16 '60	
ADDRESS Cumb. MD		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2723

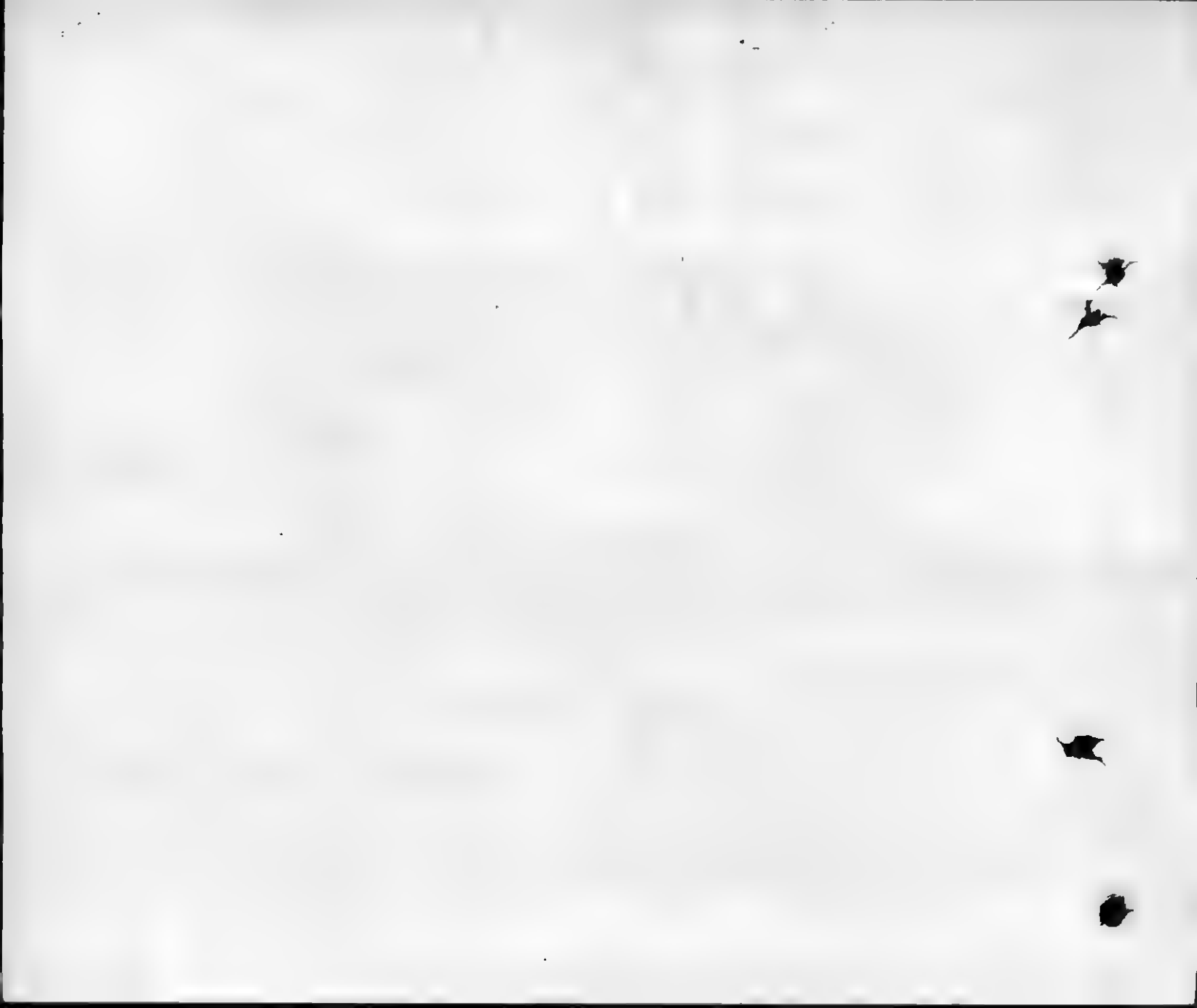
CERTIFICATE OF DEATH

02710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>55 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02Cumberland</u>		d. STREET ADDRESS <u>126 W. Oldtown Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>126 W. Oldtown Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>T.</u> Last <u>Burkett</u>				4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 9, 1886</u>	
9. AGE (In years last birthday) yrs. <u>74</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Repairman</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Washers & Etc.</u>		11. BIRTHPLACE (State or foreign country) <u>Hyndman, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Burkett</u>				14. MOTHER'S MAIDEN NAME <u>Mary Roush</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u> </u>		17. INFORMANT <u>Mrs. Geroldine Fogle</u> Address <u>126 Oldtown Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>4000</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Feb. 28, 1960</u> , to <u>April 4, 1960</u> , that I last saw the deceased alive on <u>Feb. 28, 1960</u> , and that death occurred at <u>12:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clay E. Durrett</u> M.D.				ADDRESS (Street, city or town, state) <u>236 Virginia Ave. Cumberland, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Clay E. Durrett</u>				DATE SIGNED <u>3/5/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ellicrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 8 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02711

2793

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Frostburg	c. LENGTH OF STAY IN 1b 44yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Route # 1 Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) HELEN First R. Middle CLISE Last		4. DATE OF DEATH 3/27/1960 Month 3 Day 27 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/1889
9. AGE (in years last birthday) 70 yrs		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Minutes 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own Home		10b. KIND OF BUSINESS OR INDUSTRY Frostburg MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Riggs		14. MOTHER'S MAIDEN NAME Linda Steele	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mr. Albert Clise, R.F.D. #1 Frostburg, MD. Address		(Husband)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 422.2 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE WOMC Lane		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WOMC Lane		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REBURY (Type)		22b. DATE THEREOF 3-29-60	
22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. UNERAL DIRECTOR'S SIGNATURE George Eickhorn, Lenawacoming, Md		24a. REC'D BY REGISTRAR DATE MAR 30 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE SIGNED Mar 27 1960	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, for burial, cremation, or removal, and in any event within 72 hours after death.



2794

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home-Eckhart, Md.</u>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u> d. STREET ADDRESS <u>4</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alexander</u> Middle <u>Blair</u> Last <u>Close</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rail Road</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James R. Close</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Brode</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-07-6689</u>	
17. INFORMANT <u>Nellie Close</u>		Address <u>Eckhart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma right lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Secondary anemia</u> DUE TO (c) <u>Secondary anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-15, 1959</u> to <u>3-10, 1960</u> , that I last saw the deceased alive on <u>3-9, 1960</u> , and that death occurred at <u>1A: M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.C. Diehl</u> M.D.		ADDRESS (Street, city or town, state) <u>39 W. Main St.</u> DATE SIGNED <u>3/12/60</u>	
PHYSICIAN'S NAME (Type) <u>H.C. Diehl, M.D.</u>		<u>Frostburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 13, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Enoch Fogelson</u> ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 16 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

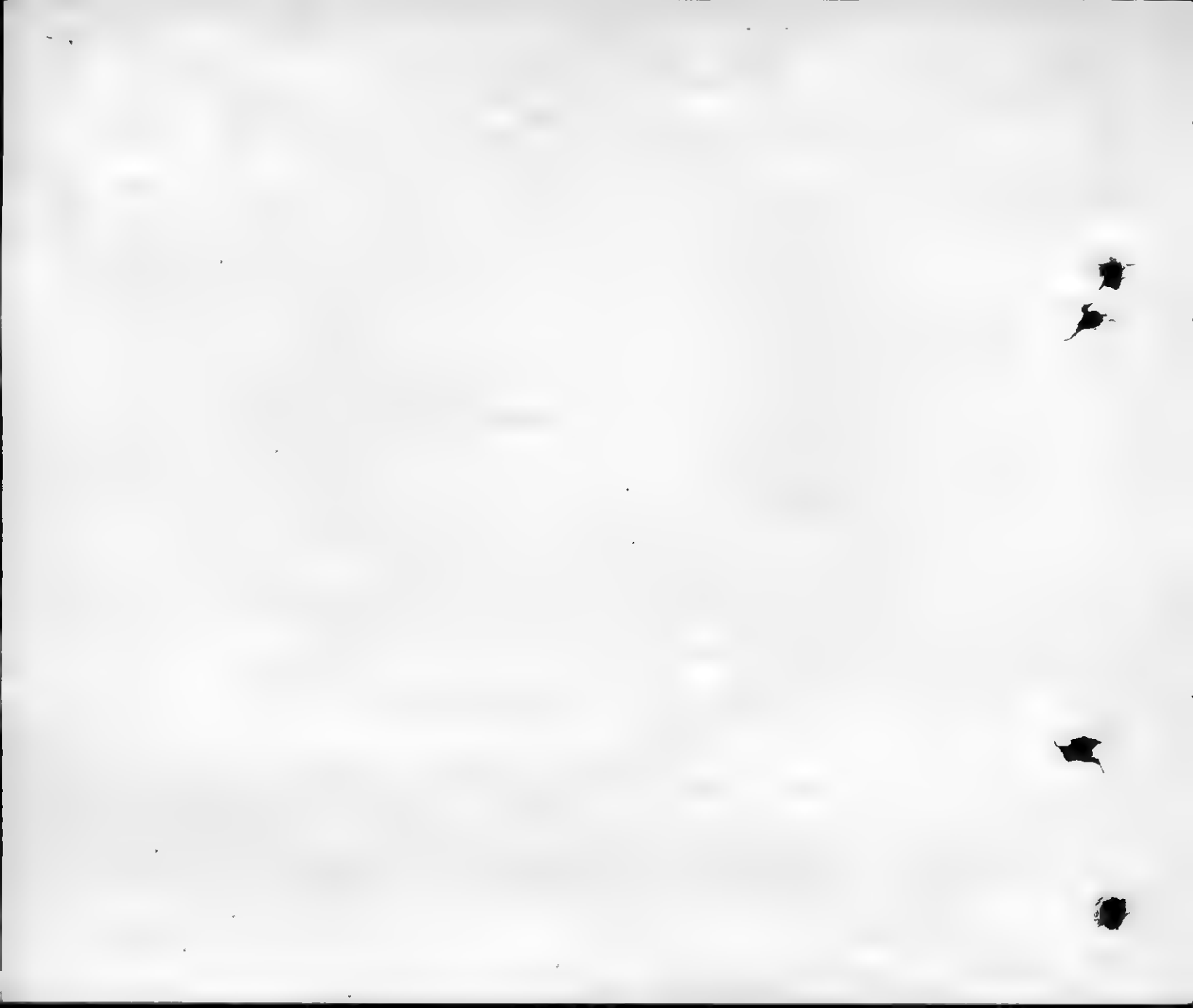
02713

2795

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellerslie</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Lester Conner</u>				4. DATE OF DEATH Month Day Year <u>March 6, 1960</u> <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1891</u>	9. AGE (In years last birthday) <u>68</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cumberland Sement</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Supplier Employee</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William T. Conner</u>				14. MOTHER'S MAIDEN NAME <u>Martha Ellen Warnick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>James Ambrose Conner, Ridgeley, W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>523.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SILICOSIS PULMONUM</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> , p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JANUARY 1960</u> to <u>MARCH 1960</u> , that I last saw the deceased alive on <u>3-6</u> , 19 <u>60</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>OTTO VOGEL M.D.</u>		ADDRESS (Street, city or town, state) <u>MAIN ST RT 1446</u>		DATE SIGNED <u>M.D.</u>			
PHYSICIAN'S NAME (Type) <u>OTTO VOGEL, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 9, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hyndman, Pa. RD #1</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Leigler</u>		ADDRESS <u>Hyndman, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Proulx</u>	



2724

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>Bedford</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>21 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address and name of institution) <u>Memorial Hospital Memorial Aves.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jonas</u>		First <u>Jonas</u> Middle <u>Coughenour</u> Last <u>Coughenour</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1870</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Hyndman, Pa.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Daniel Coughenour</u>				14. MOTHER'S MAIDEN NAME <u>Susan Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-09-9039</u>		17. INFORMANT <u>Russel Coughenour, Hyndman, Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic generalized senile A.S.C.V.D.</u> INTERVAL BETWEEN ONSET AND DEATH <u>Approx 15 yrs.</u>							
DUE TO <u>4-1-1</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO <u> </u>							
DUE TO <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<u>Pneumonitis, left lower lobe</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>after Jan 1960</u> to <u>Mar 31, 1960</u> , that I last saw the deceased alive on <u>March 30, 1960</u> , and that death occurred at <u>6:17 a.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Topper</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Dr. John Topper</u>				<u>Hyndman, Pennsylvania</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 3, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hyndman Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hyndman, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>				ADDRESS <u>Hyndman, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 5 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event within 72 hours after death, register prior to burial, cremation, or removal.

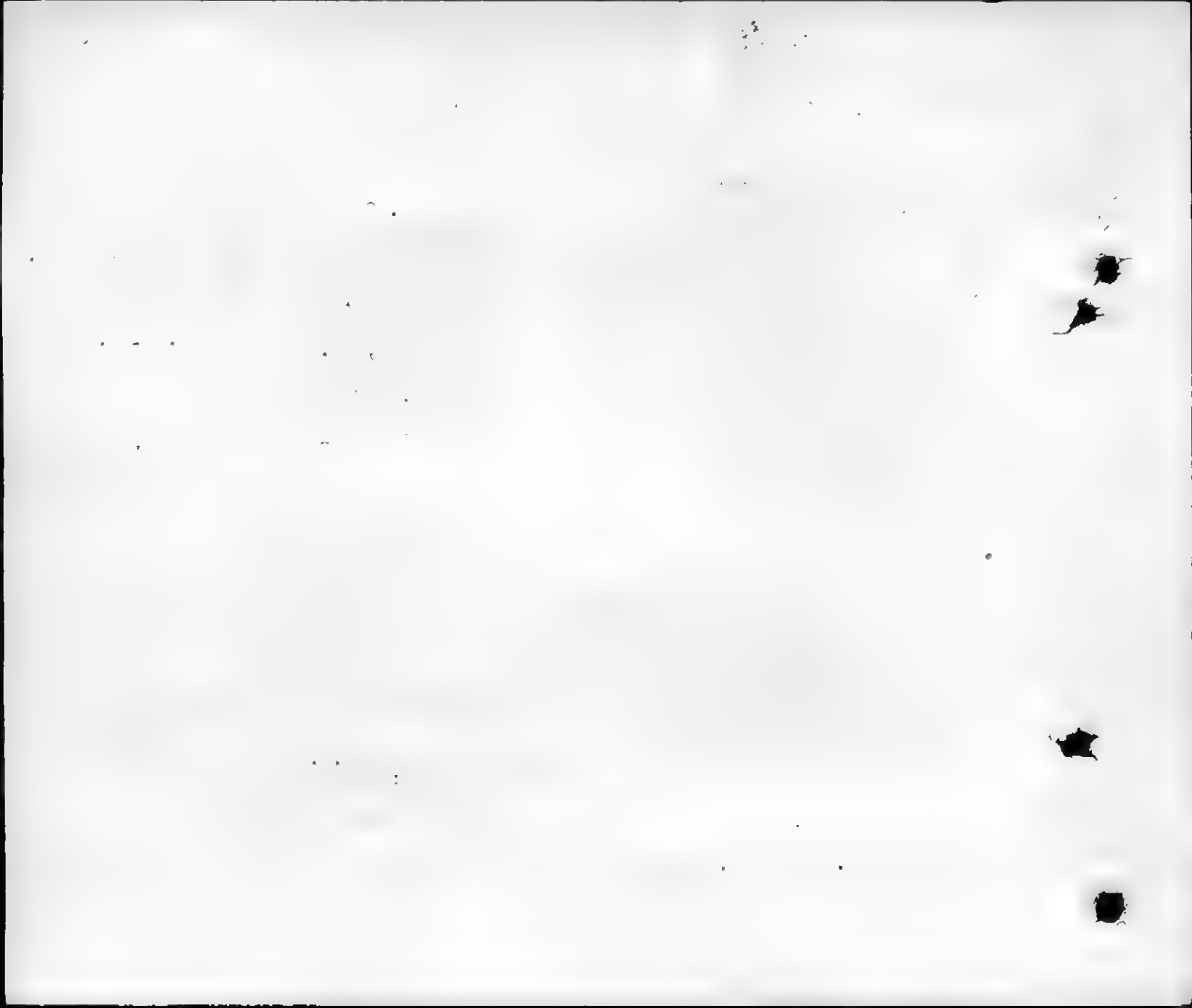


1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2725
CERTIFICATE OF DEATH

02715

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 5 HOURS			
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BABY BOY Middle DEVER Last DEVER				4. DATE OF DEATH Month MARCH Day 22 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 22, 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs 5 2	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME GEORGE DEVER				14. MOTHER'S MAIDEN NAME NELLIE M. KISNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spontaneous rupture of the aorta DUE TO (c) Immaturity of vital structures							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 20 March 1960 , P.M., that (I) (we) last saw the deceased alive on 22 March 1960 , and that death occurred at 10:10 from the causes and on the date stated above.							
22a. SIGNATURE Leland B. Ransom				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) DR. LELAND B. RANSOM	
22d. ADDRESS 63 Green St.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-23-60		23c. NAME OF CEMETERY OR CREMATORY Dever Cem		23d. LOCATION (City, town, or county) (State) Wiley Ford, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR MAR 28 '60	
				25b. REGISTRAR'S SIGNATURE Carlton S. K...			

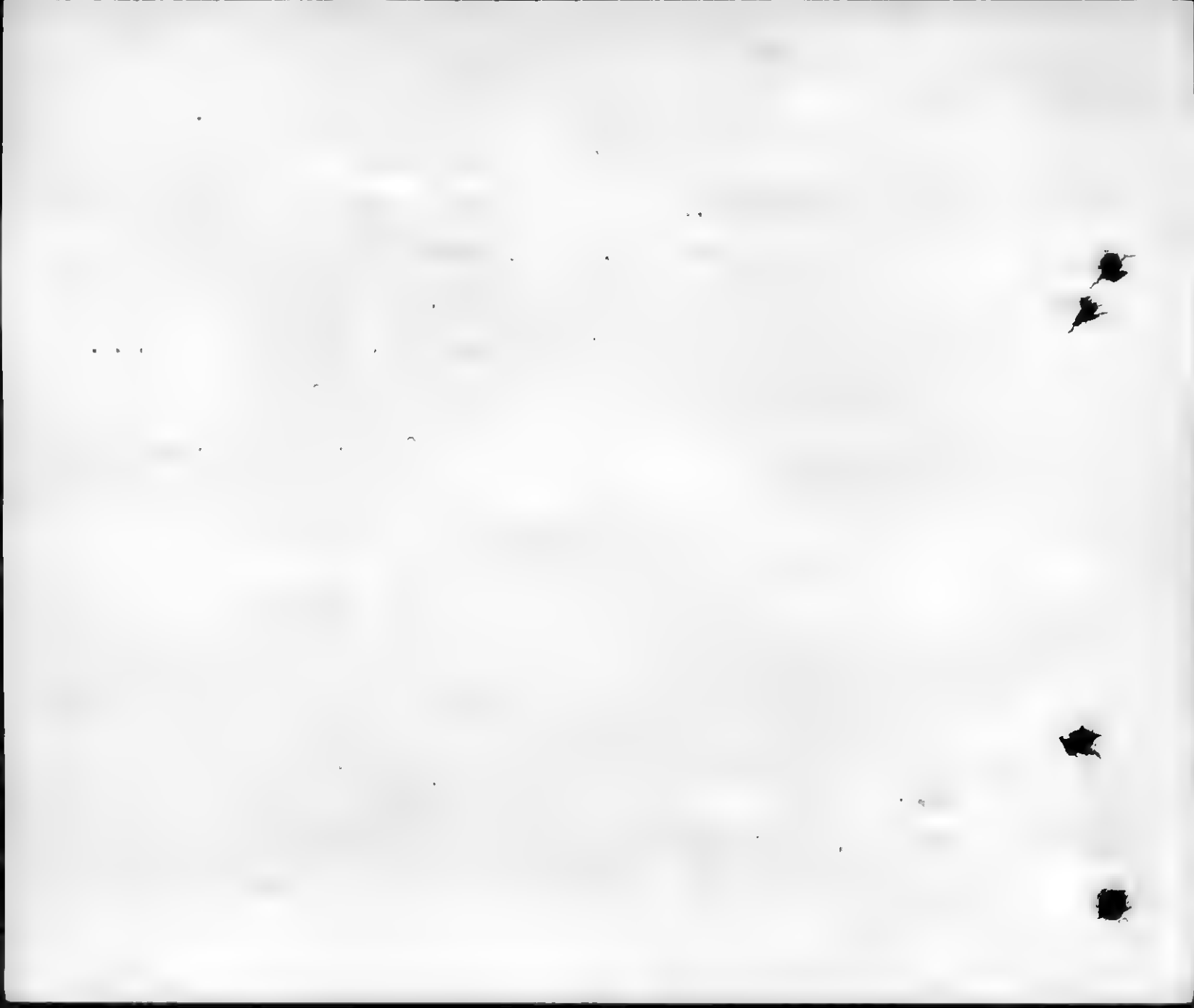
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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2726
CERTIFICATE OF DEATH

02716

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 9 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NORWOOD Middle M. Last EDMONDSON				4. DATE OF DEATH Month MARCH Day 9 Year 1960			
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 29, 1936		9. AGE (In years last birthday) 23 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician				10b. KIND OF BUSINESS OR INDUSTRY Bettors Orchestra		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME MELVIN EDMONDSON				14. MOTHER'S MAIDEN NAME LENORA RICHARDSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-8274		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA, BILATERAL 204.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE MONOCYTIC LEUKEMIA DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 45-60 min's 9 mo
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7 NOV 19 57 to 9 MARCH 19 60 , that (I) (we) last saw the deceased alive on 9 MARCH 19 60 , and that death occurred at 9:15 AM from the causes and on the date stated above.							
22a. SIGNATURE L. Michael Glick				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) L. MICHAEL GLICK	
22d. ADDRESS				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		Mar 12 1960		Woodlawn Cemetery		Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				25a. REC'D BY REGISTRAR DATE MAR 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

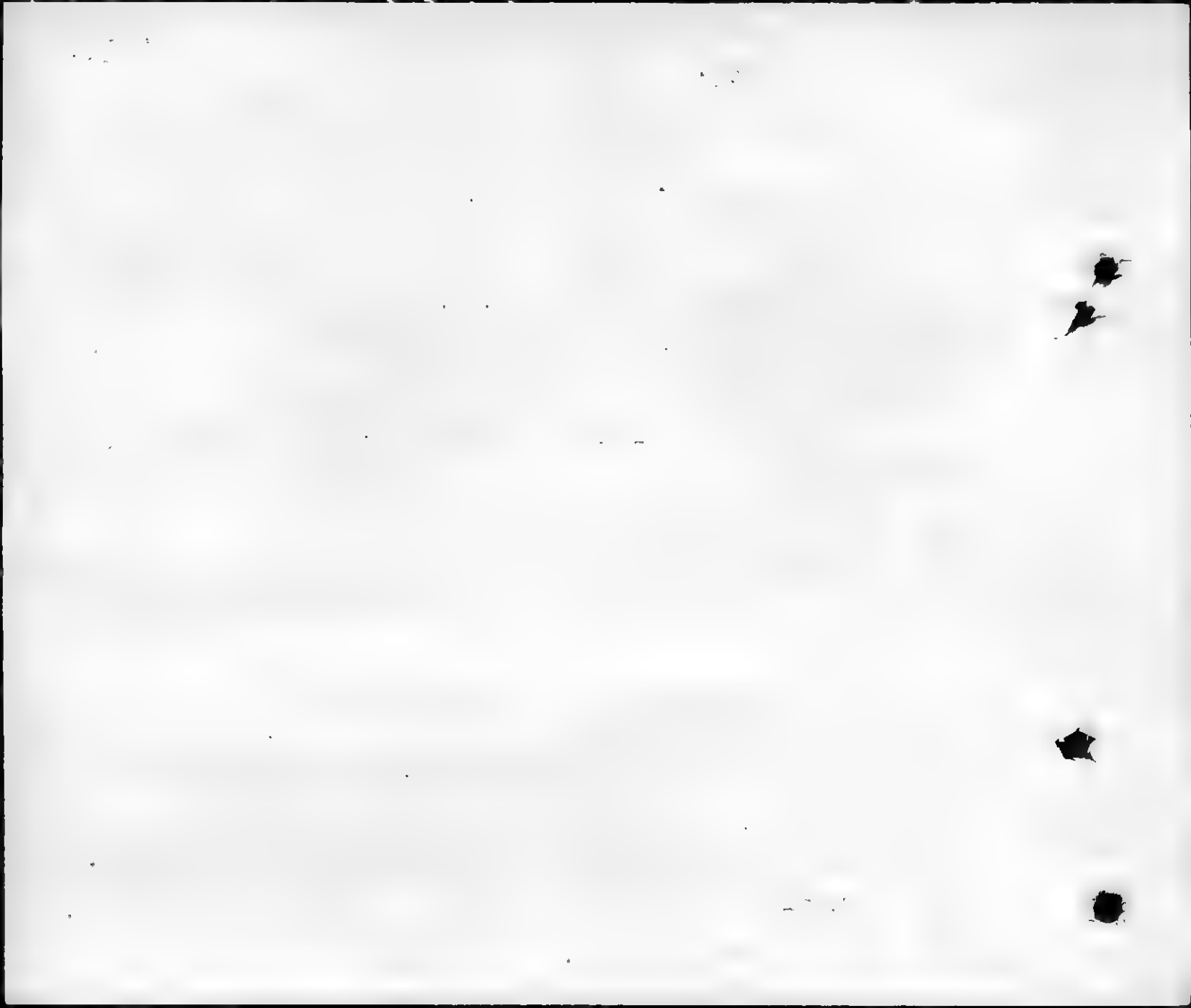


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2774 **CERTIFICATE OF DEATH**

02717

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		/d. STREET ADDRESS 152 GREEN ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM STANLEY EISEL		4. DATE OF DEATH Month Day Year MARCH 30, 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 8, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR, SPINNING -		10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE EISEL		14. MOTHER'S MAIDEN NAME SARAH GUNTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-01-3644	
17. INFORMANT MRS. NELLIE EISEL, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 523.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 16 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Tuberculosis , 19 56 , to 3/30 , 19 60 , that (I) (we) last saw the deceased alive on 3/30 , 19 60 , and that death occurred at 2 PM , from the causes and on the date stated above.			
22a. SIGNATURE MARTIN ROTHSTEIN, M. D.		22b. DATE 3/30/60	
22c. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-1-1960	
23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst		25a. REC'D BY REGISTRAR APR 4 '60	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the State Board of Health requires that the death certificate be executed within 24 hours after death. Page 4

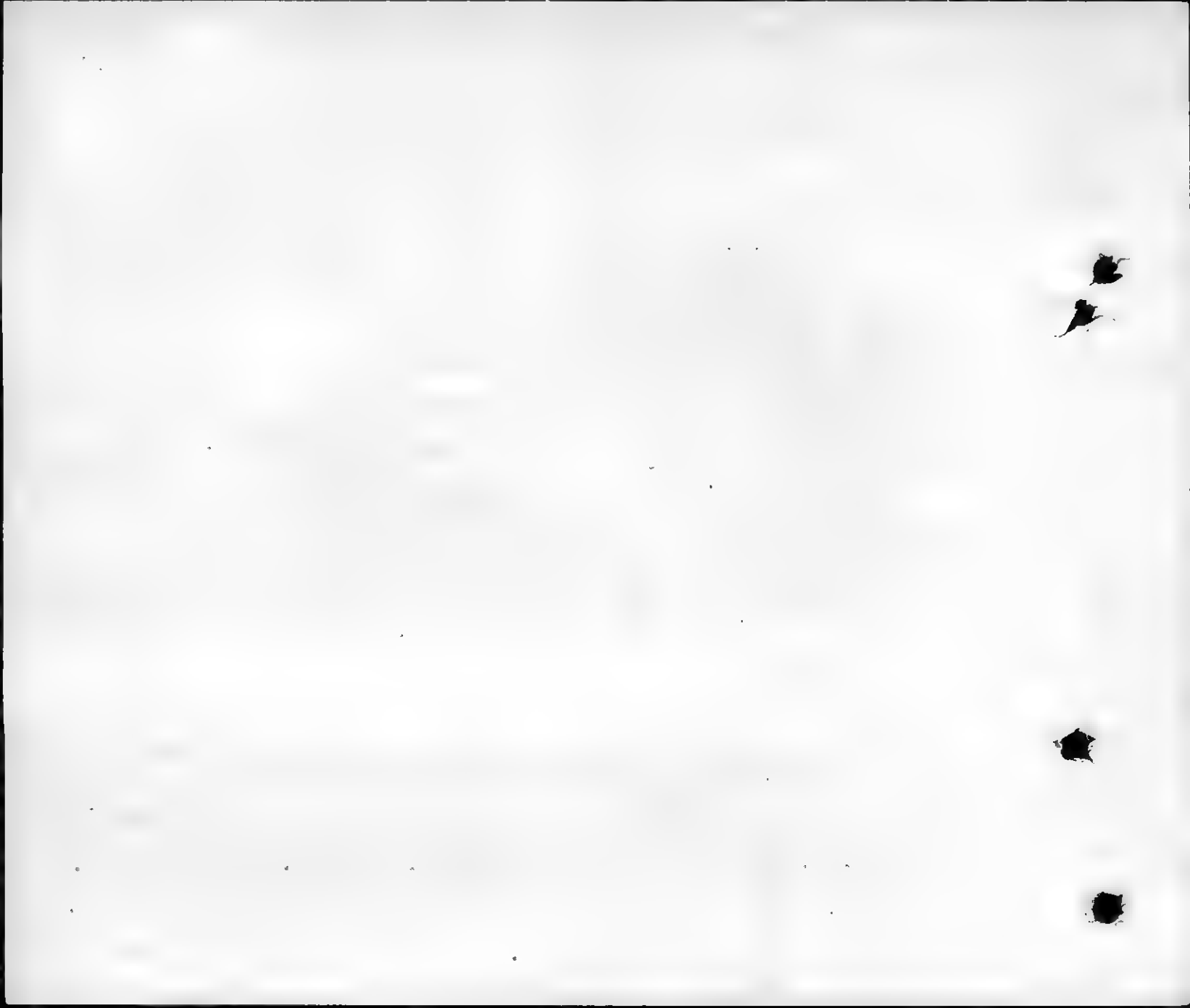


may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. The 1 and 2 should be filed with the State Board of Health.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 2795
 CERTIFICATE OF DEATH

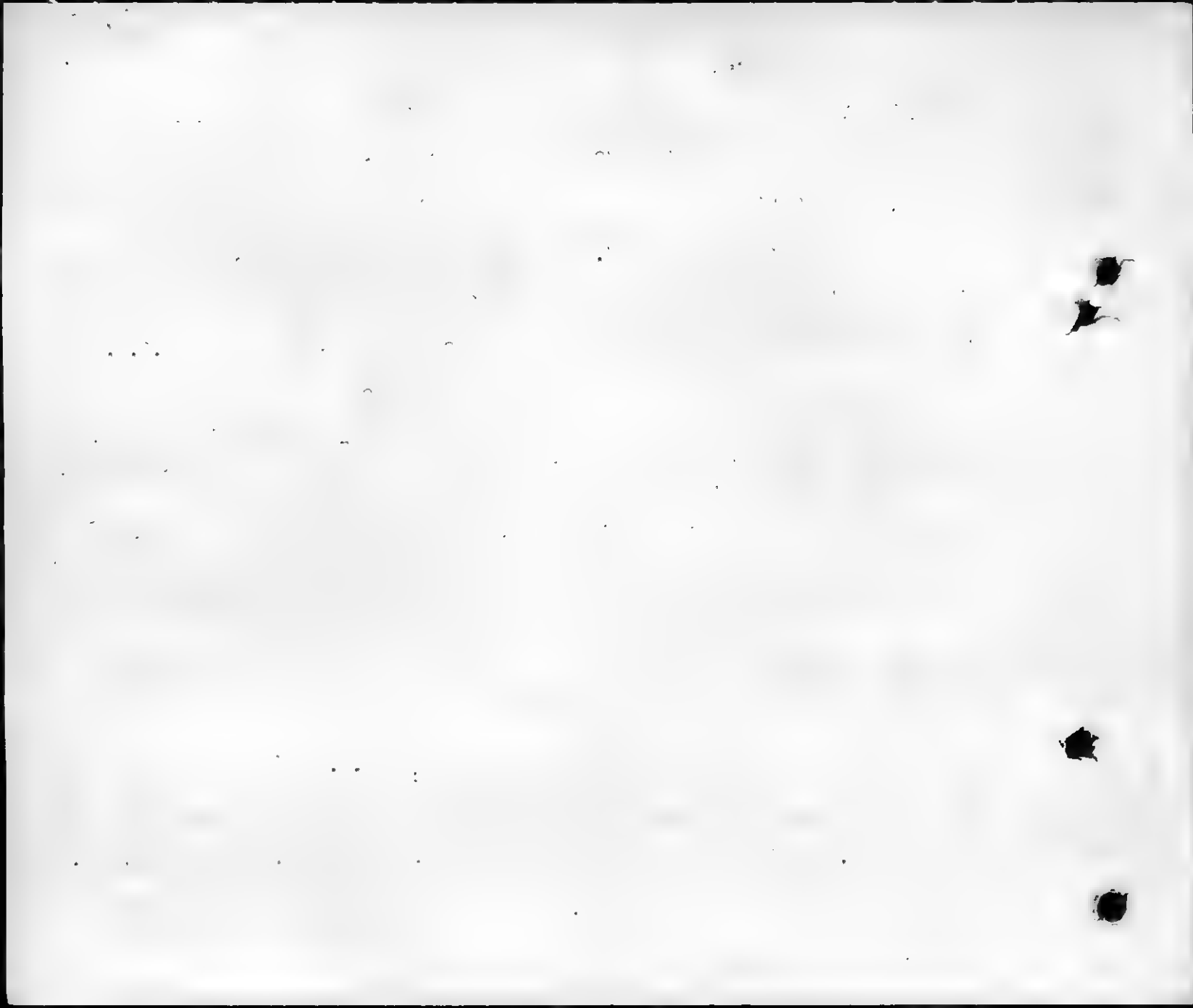
02718

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart			
c. LENGTH OF STAY IN 1b Lifetime				d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Cecilia Middle Estella Last Engle				4. DATE OF DEATH Month March Day 23rd Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10th, 1880		9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own housework		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Josiah Porter				14. MOTHER'S MAIDEN NAME Elizabeth Race			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none		17. INFORMANT Lester Engle, Eckhart, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 32X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pericious Anaemia						INTERVAL BETWEEN ONSET AND DEATH 12 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1956 to Mar 23 , 1960 that (I) (we) last saw the deceased alive on Mar 22 , 1960 and that death occurred at 7:45 PM from the causes and on the date stated above.							
22a. SIGNATURE W. O. McLane				22b. DATE Mar 24/1960		22c. PHYSICIAN'S NAME (Type) W. O. McLane	
22d. ADDRESS 167 E. Main St., Frostburg, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-26-60		23c. NAME OF CEMETERY OR CREMATORY Zion Evang. & Reform. Cem.		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst				25a. REC'D BY REGISTRAR DATE MAR 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



02719

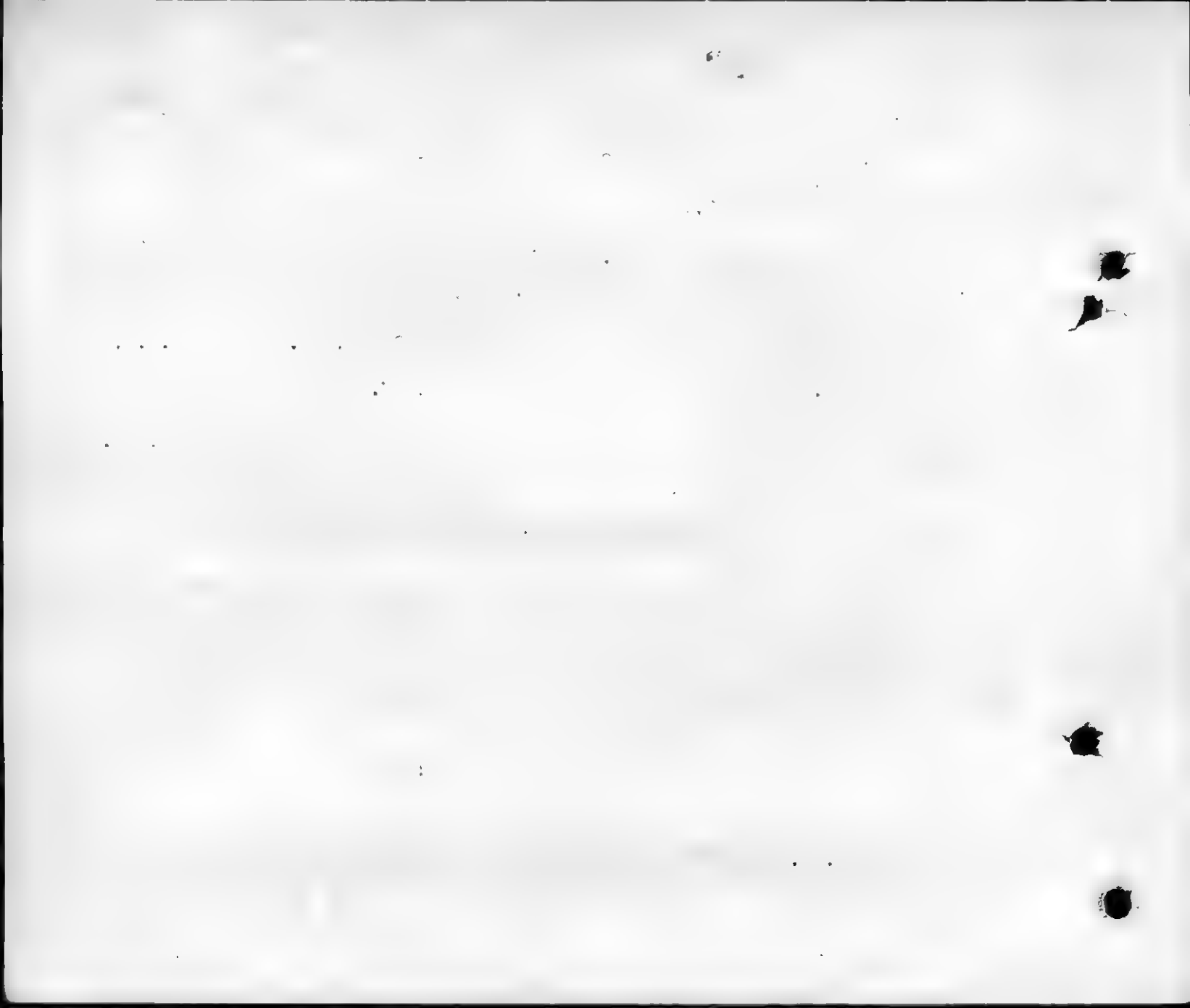
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 15 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS MASON ROAD Route 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KIZZIE Middle W. Last FAGAN				4. DATE OF DEATH Month MARCH Day 23 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 19, 1910	
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA, Paw Paw		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GARFIELD BUCY				14. MOTHER'S MAIDEN NAME ABBY KERNS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis DUE TO 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral Valve Sclerosis DUE TO (c) Mixed Mesodermal Mesoblastic fibrosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 days app 2 wks 7 m							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 1959 to Mar. 25, 1960 that (I) (we) last saw the deceased alive on 3/22/60 19 60 , and that death occurred at 4:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Lewis Mould				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE March 23, 1960	
22c. PHYSICIAN'S NAME (Type) DR. LEWIS MOULD				22d. ADDRESS 122 So. Centre St. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/25/60		23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				ADDRESS John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR MAR 28 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND.
 2728
 CERTIFICATE OF DEATH

02720

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JULIA Middle G. Last FLETCHER				4. DATE OF DEATH Month MARCH Day 16 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 29, 1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) BORDEN SHAFT, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN D. BARNARD				14. MOTHER'S MAIDEN NAME FRANCES V. HOPWOOD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. —		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442X DUE TO Arterio-sclerotic cardiac Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular renal disease DUE TO (Uremia) (c) —							INTERVAL BETWEEN ONSET AND DEATH 9
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 3-12-1960 to 3-16-1960 , that (I) (we) last saw the deceased alive on 3-16-1960 and that death occurred at 10:45 AM from the causes and on the date stated above.							
22a. SIGNATURE W. F. Williams M.D.				22b. DATE SIGNED 3-17-60		22c. PHYSICIAN'S NAME (Type) W. F. WILLIAMS	
22d. ADDRESS CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/19/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stee Inc				ADDRESS Cum. Md.		25a. REC'D BY REGISTRAR DATE MAR 21 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Kraus							



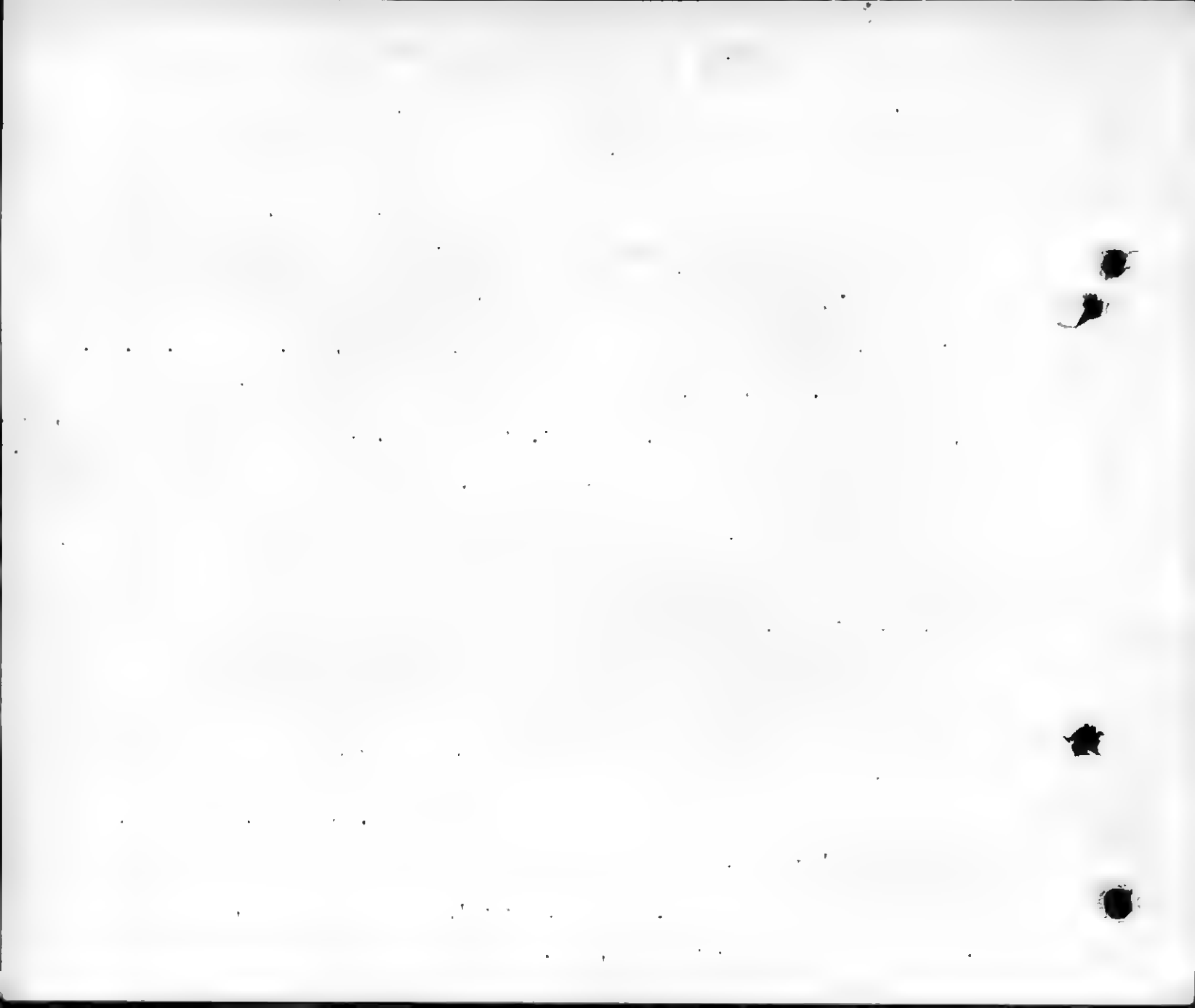
2729

CERTIFICATE OF DEATH

Reg. Dist. No.

02721

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
c. LENGTH OF STAY IN 1b 5 HOURS				d. STREET ADDRESS 705 FREDERICK ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle Vincent Last FLETCHINGER				4. DATE OF DEATH Month MARCH Day 2 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 5, 1891	
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired pressman				10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
13. FATHER'S NAME George J. Fletcher				14. MOTHER'S MAIDEN NAME Ella Mae Christi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. 214-05-9575			
17. INFORMANT Mrs. Mildred A. Fletcher				Address Cumberland, Md. 705 Frederick St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident (embolus) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Myocardial fibrosis DUE TO (c) Coronary arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH immediate 11 yrs. ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Squamous cell carcinoma penis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 18, 1952 to March 2, 1960 , that I last saw the deceased alive on March 2, 1960 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing St. Cumberland, Md. DATE SIGNED 3/4/60							
ACTUAL SIGNATURE Samuel M. Jacobson M.D.				PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/60		22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE MAR 7 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



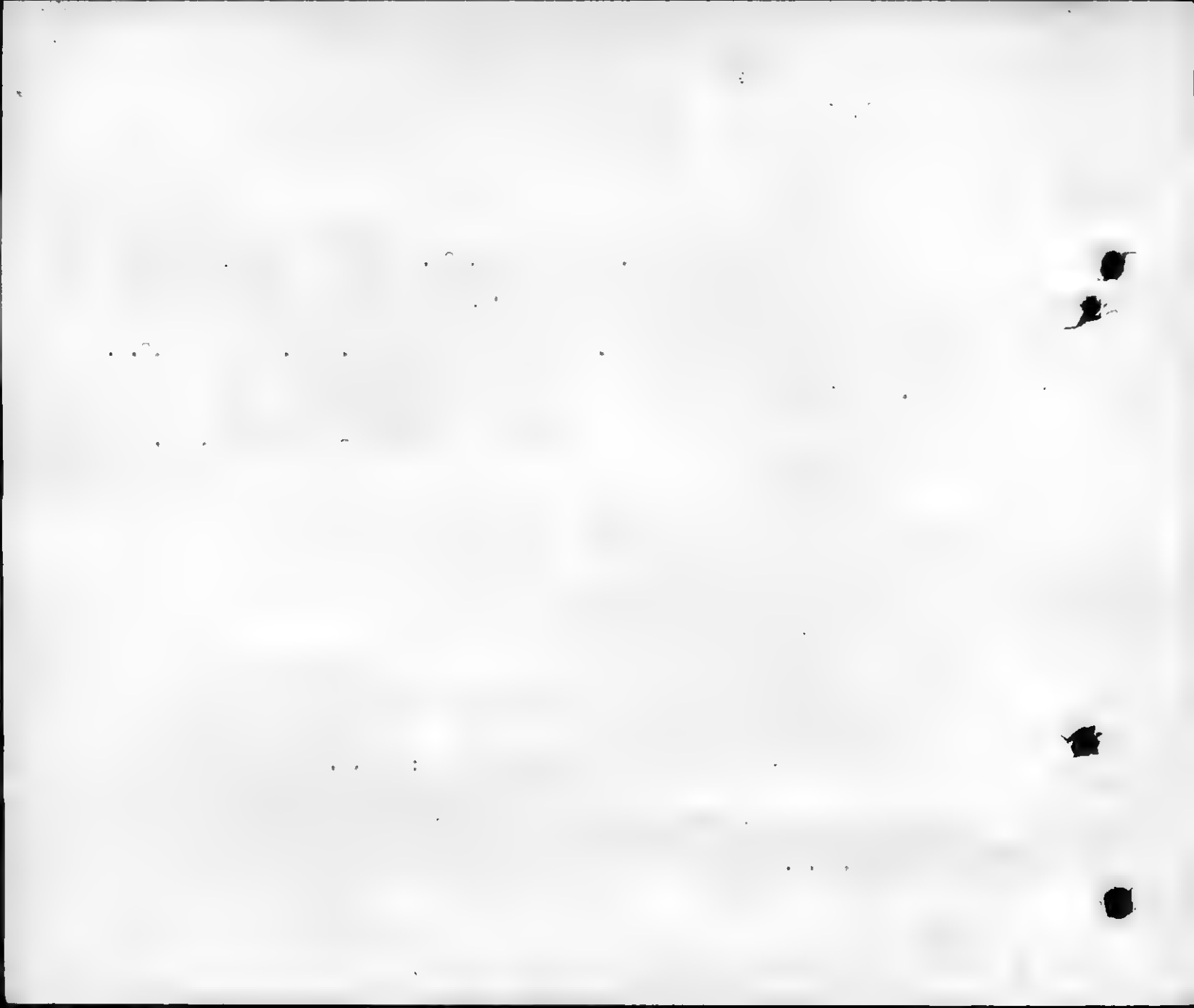
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2730

02722

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 53 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MEYERSDALE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS ROUTE #4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD W. FRIZZELL, SR.				4. DATE OF DEATH Month Day Year MARCH 30 1960			
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 3, 1907		9. AGE (In years last birthday) 53 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY FIRE DEPT.		11. BIRTHPLACE (State or foreign country) BALTIMORE CO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN C. FRIZZELL				14. MOTHER'S MAIDEN NAME KATHERINE HAUPT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO		16. SOCIAL SECURITY NO 218-32-3377		17. INFORMANT WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction DUE TO (c) Coronary Artery Disease							INTERVAL BETWEEN ONSET AND DEATH 53 days 53 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral phlebotomies - Bronchial asthma							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 3-30, 1960 that (I) (we) lost the deceased alive on 3-30, 1960 and that death occurred of 2:55 A.M. from the causes and on the date stated above.							
22a. SIGNATURE William P. James, MD				22b. DATE SIGNED 3-31-60		22c. PHYSICIAN'S NAME (Type) DR. W.P. JAMES	
22d. ADDRESS 441 N. Centre St., Cumberland, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 2, 1960		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City, town, or county) (State) Woodlawn Md	
24. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury - 6411 Windsor M. H. Rd #7				25a. REC'D BY REGISTRAR DATE APR 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2731 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital--DOA</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u> d. STREET ADDRESS <u>613 Frederick St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Max</u> Middle <u>GERSON</u> Last <u>GERSON</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>17</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 16, 1916</u>			
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland Md U. S. A.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Michael Gerson</u>			
14. MOTHER'S MAIDEN NAME <u>Sanna Swartz</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Mrs. Ida From</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, left</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Sclerosis</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 17, 1960</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/18/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East View Cem</u>			
22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. Cumb. Md</u>					
24a. REC'D BY REGISTRAR <u>MAR 21 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. From</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

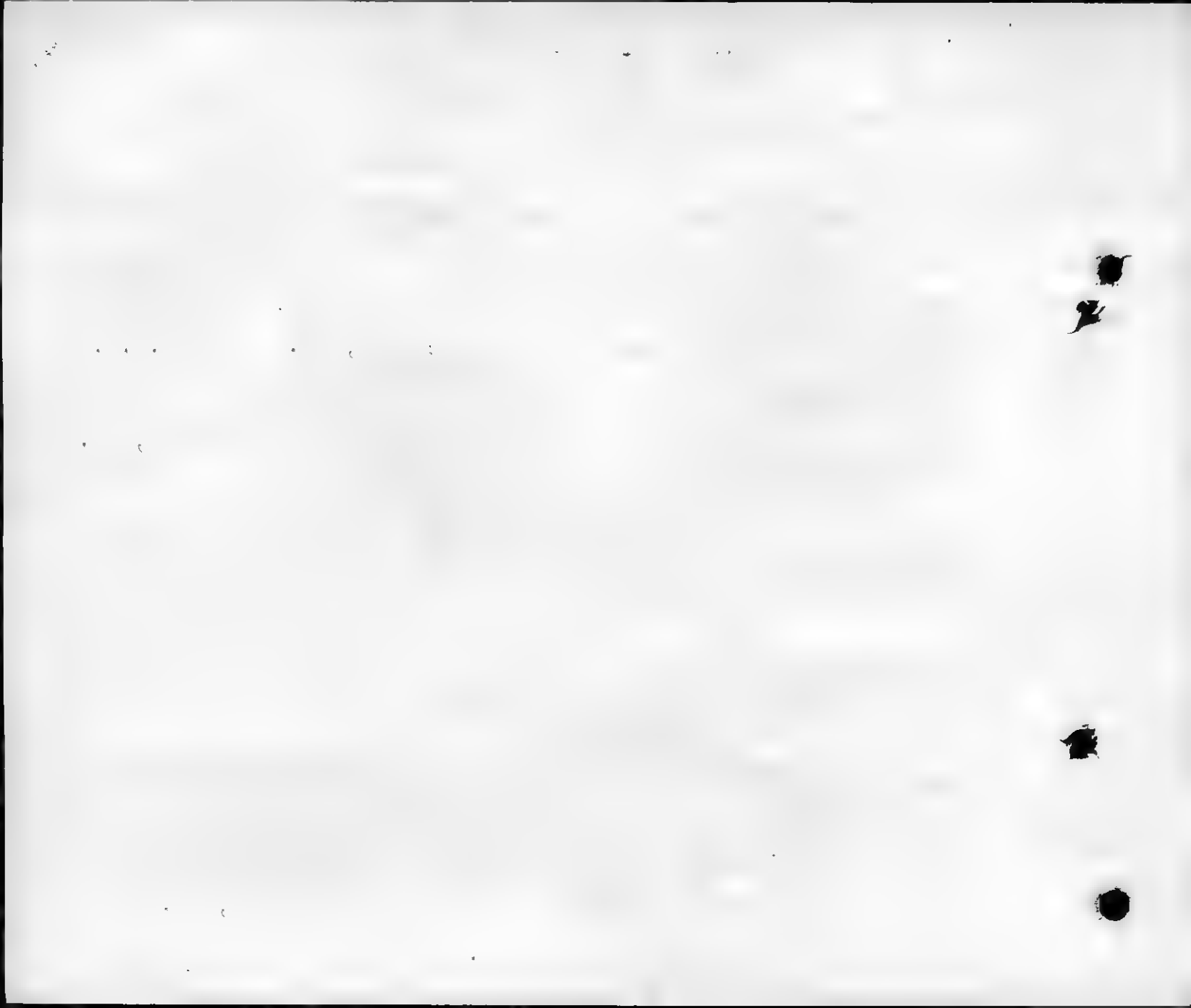


may be retained by the hospital or attending physician
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 2, page 1 and 2 should be filed with the State Board of Health for no burial, cremation, or removal, and in any event, within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 2775 CERTIFICATE OF DEATH

02724

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS East Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ADA Middle BARNES Last GETSON		4. DATE OF DEATH Month 3 Day 28 Year 1960	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17/1893
9 AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6 Days 7 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Barnes		14. MOTHER'S MAIDEN NAME Catherine Spicher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Charles Getson		Address Lonaconing, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) years		INTERVAL BETWEEN ONSET AND DEATH 6 hr.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (HUSBAND)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 6:30 to 3:28 , 19 60 , that (I) (we) last saw the deceased alive on 3:28 , 19 60 and that death occurred at 2:28 PM, from the causes and on the date stated above			
22a. SIGNATURE L. R. Miles		22b. DATE SIGNED 3-29-60	
22c. PHYSICIAN'S NAME (Type) L. R. MILES JR., M.D.		22d. ADDRESS LONA CONING MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/31/1960	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, MD.	
24 FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		25a. REC'D BY REGISTRAR DATE MAR 30 '60	
ADDRESS LONA CONING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Klaus	



CERTIFICATE OF DEATH

Reg. Dist. No.

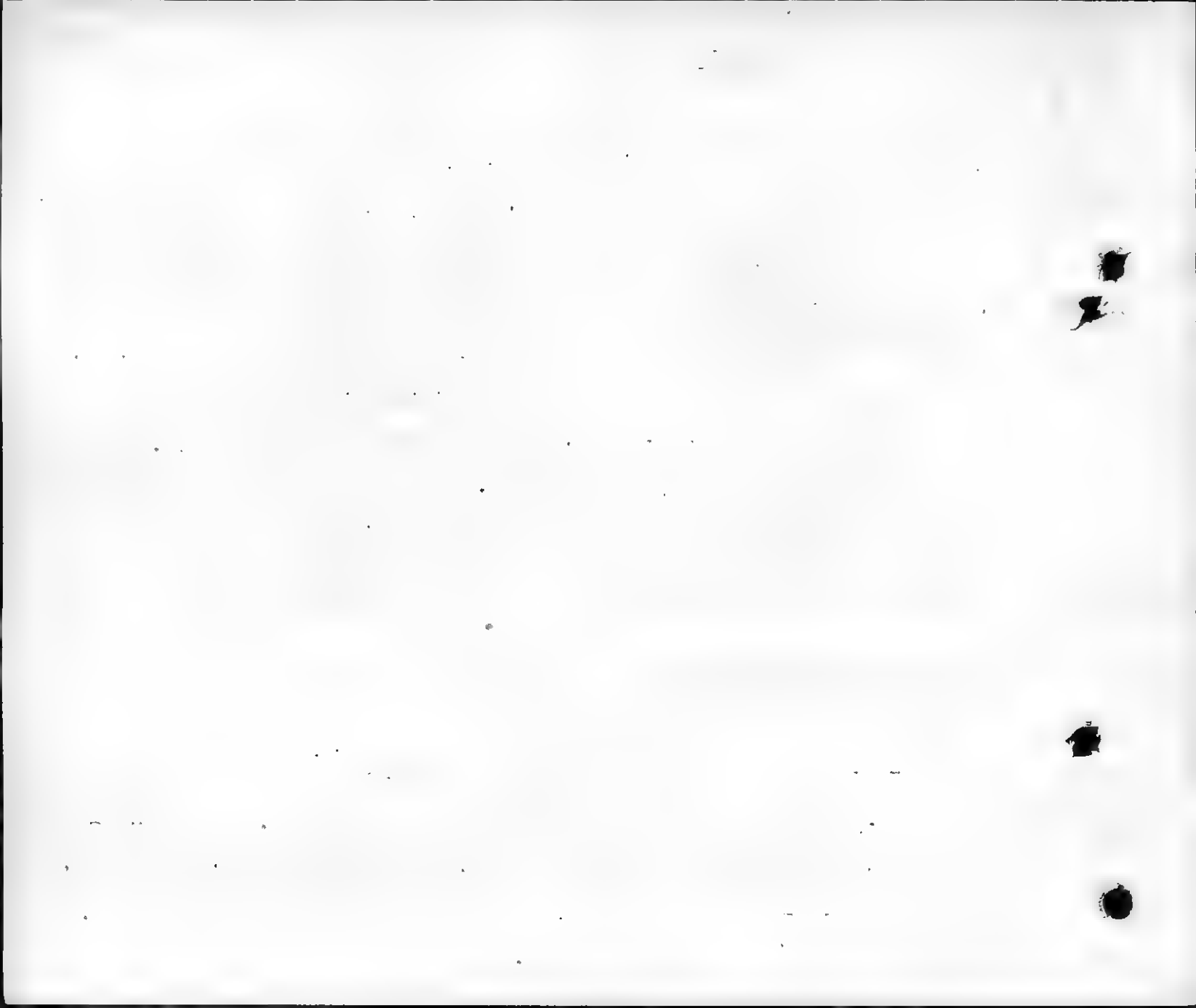
02725

2732

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN lb 90 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Laura Mae Glime				4. DATE OF DEATH Month Day Year March 23 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/13/86	
9. AGE (In years lost birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Chaney				14. MOTHER'S MAIDEN NAME Josephine Porter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-10-4383			
17. INFORMANT Gilbert Glime,				25106 Oak Drive, Damascus, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adeno-Ca c metastases, original site 199.2 DUE TO unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 12 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-12-59 , 19 to 3-23-60 , 19, that I last saw the deceased alive on 3-23-60 , 19, and that death occurred at 12:40p from the causes and on the date stated above.							
ACTUAL SIGNATURE Pres. W. Brown				ADDRESS (Street, city or town, state) 62 Greene St.		DATE SIGNED 3-24-60	
PHYSICIAN'S NAME (Type) Dr. Ralph Ballin				62 Green Street Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-60		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. K. Overst				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE MAR 28 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kiana	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2733

CERTIFICATE OF DEATH

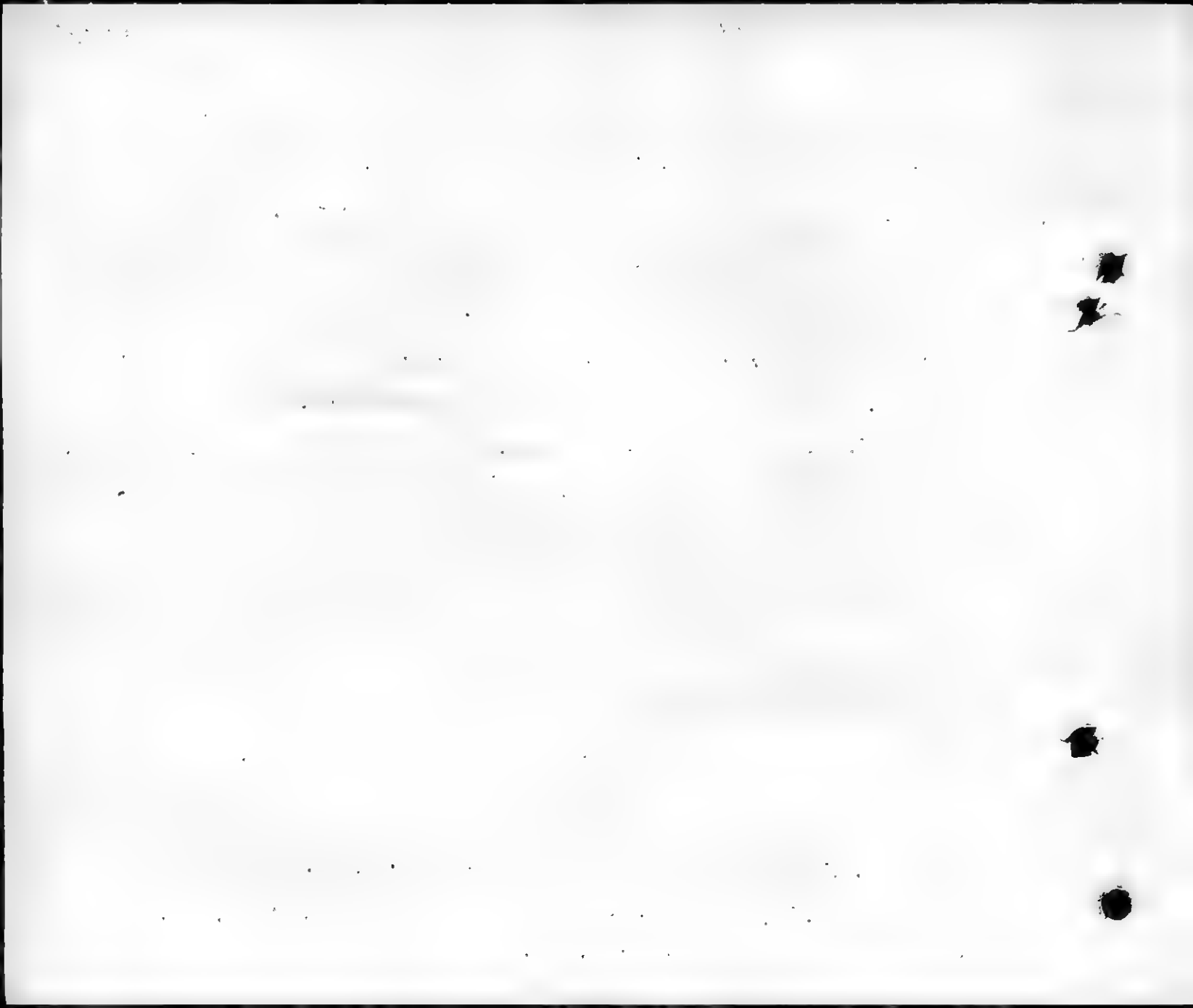
Reg. Dist. No.

02726

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>319 Williams St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>A.</u> Last <u>Graham</u>			4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>19 60</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/17/90</u>	
9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Linatype opr.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>		11. BIRTHPLACE (State or foreign country) <u>W.Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John A. Graham</u>				14. MOTHER'S MAIDEN NAME <u>Emma Lee Israel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>W. W. 1 214-05-6198</u>		17. ADDRESS <u>Mrs. Samuel Graham 319 Williams St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>422.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost, (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT.ON GIVEN IN PART I (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour _____ o. m. _____ p. m. _____			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>3-21</u> , 19 <u>60</u> , to <u>3-23</u> , 19 <u>60</u> ; that I last saw the deceased alive on <u>3-23</u> , 19 <u>60</u> , and that death occurred at <u>3:40 AM</u> , from the causes and on the date stated above.							ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>3-24-60</u>
ACTUAL SIGNATURE <u>William P. James</u> M.D. _____							
PHYSICIAN'S NAME (Type) <u>Dr. W. James</u> _____ <u>111 N Center St. Cumberland, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 25, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requirement that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2776

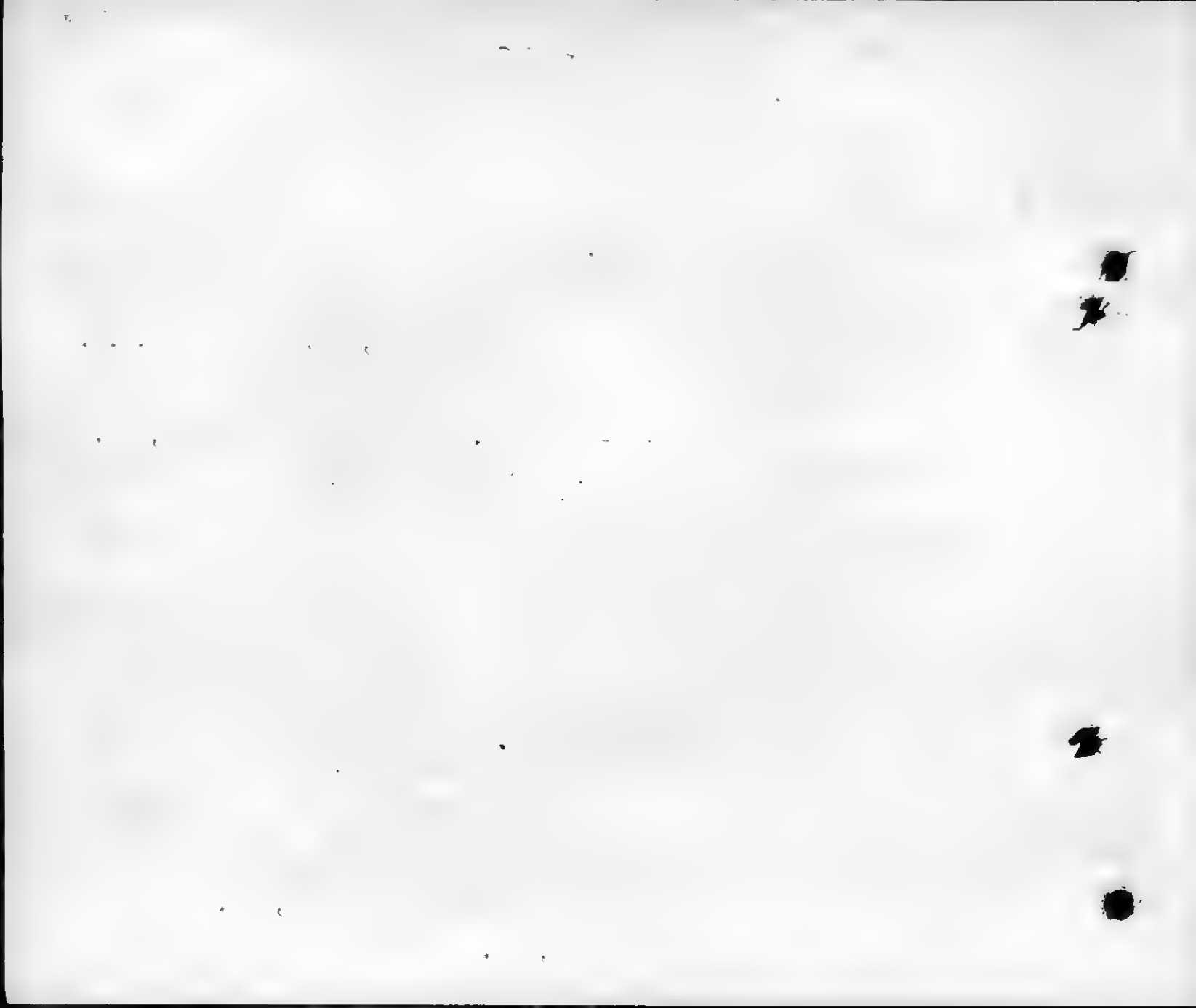
Item 8, Film 0259 3/21/60 1b

CERTIFICATE OF DEATH

02727

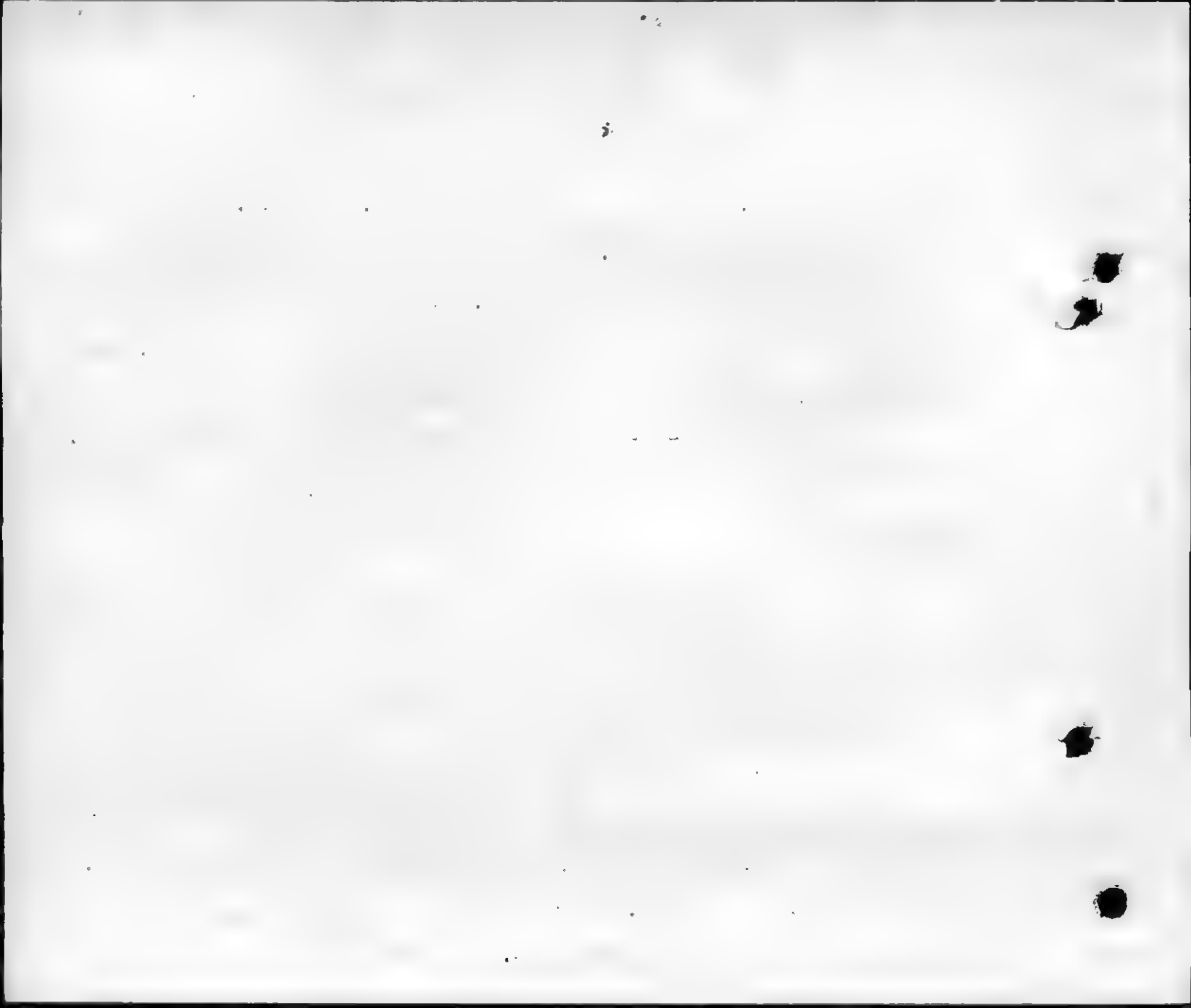
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) MIDLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle E. Last GRAY		4. DATE OF DEATH Month 3/12/1960 Day 19 Year 19	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/1909
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 5 Days 12 Hours 0 Min 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION WORKER		10b. KIND OF BUSINESS OR INDUSTRY KLONDYKE, MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK GRAY		14. MOTHER'S MAIDEN NAME AGNES DOUGLAS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-18-1467	
17. INFORMANT MRS. JANE DUNN		Address MIDLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 480X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Influenza DUE TO (c) (SISTER)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar 7 1960 to Mar 12 1960 that (I) (we) lost the deceased on Mar 12 1960 and that death occurred 9:45 AM on the causes and on the date stated above.			
22a. SIGNATURE W O Mc Lane M D		22b. DATE MAR 14 1960	
22c. PHYSICIAN'S NAME (Type) W O Mc Lane M D		22d. ADDRESS Frostburg Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/15/1960	23c. NAME OF CEMETERY OR CREMATORY LAUREL HILL CEMETERY	23d. LOCATION (City, town, or county) (State) MOSCOW, MD.
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		25a. REGISTRY REGISTRAR ADDRESS LONACONING, MD.	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans		25c. REGISTRY REGISTRAR DATE MAR 16 60	

MEDICAL CERTIFICATION



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2777
02728
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 326 E. MAIN ST.				d. STREET ADDRESS 326 E. MAIN ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) SIMEON First W. Middle GREEN Last				4. DATE OF DEATH MARCH Month 23 , Day 19 , Year 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 4, 1891	9. AGE (In years lost birthday) 69 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF-EMPLOYED				10b. KIND OF BUSINESS OR INDUSTRY GARAGE OWNER		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME BENJAMIN H. GREEN				14. MOTHER'S MAIDEN NAME JANE WEIR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-32-8300			
17. INFORMANT MRS. LILLIAN GREEN, FROSTBURG, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MARCH 4, 1960 to MARCH 23, 1960 , that (I) (we) last saw the deceased alive on MARCH 23, 1960 , and that death occurred at 4 AM , from the causes and on the date stated above.							
22a. SIGNATURE Martin Rothstein, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/24/60	
22c. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.				22d. ADDRESS BROADWAY, FROSTBURG, MD.			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
BURIAL		3-26-60		F'bg. Memorial Park		Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Duret				ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR MAR 28 '60	
				25b. REGISTRAR'S SIGNATURE C. P. P. H. H.			



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02729

2734

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND Rt. # 5			
c. LENGTH OF STAY IN 1b 3 DAYS				d. STREET ADDRESS Triple Lakes			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE Washington HARPER				4. DATE OF DEATH Month Day Year MARCH 28 1960			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 5, 1883	9 AGE (In years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED laborer				10b. KIND OF BUSINESS OR INDUSTRY WYCKOFF STEEL CO.		11 BIRTHPLACE (State or foreign country) HARDY CO., W.VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM HARPER				14. MOTHER'S MAIDEN NAME MARY Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
17. INFORMANT WARWICK & MEMORIAL AVENUE							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis & uremia 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) arteriosclerosis, Chronic cystitis				INTERVAL BETWEEN ONSET AND DEATH ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State) 60 328-60			
21. I certify that (I) (this hospital) attended the deceased from 2-11-60 to 3-28-60 , that (I) (we) last saw the deceased alive on 3-27-60 and that death occurred at 3:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Howard L. Tolson				22b. DATE 3/28/60			
22c. PHYSICIAN'S NAME (Type) DR. HOWARD L. TOLSON				22d. ADDRESS Cumberland, Md.			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/30/60		23c. NAME OF CEMETERY OR CREMATORY Sewickley Cemetery		23d. LOCATION (City, town, or county) (State) Sewickley, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				25a. REC'D BY REGISTRAR DATE MAR 30 '60			
ADDRESS Cumberland, Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

MEDICAL CERTIFICATION

4ER: This certificate should be ex-
ne word "pending" in pencil in Item 1 within 24 hours of the
of Examiner's Office along with form PH-1, Page 5 may be re-
ould be used as a burial-transit permit. File pages 1 and 2.

DEPUTY MEDICAL
re the certificate, w
rwarded to the Chief
UNERAL DIRECTOR
or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

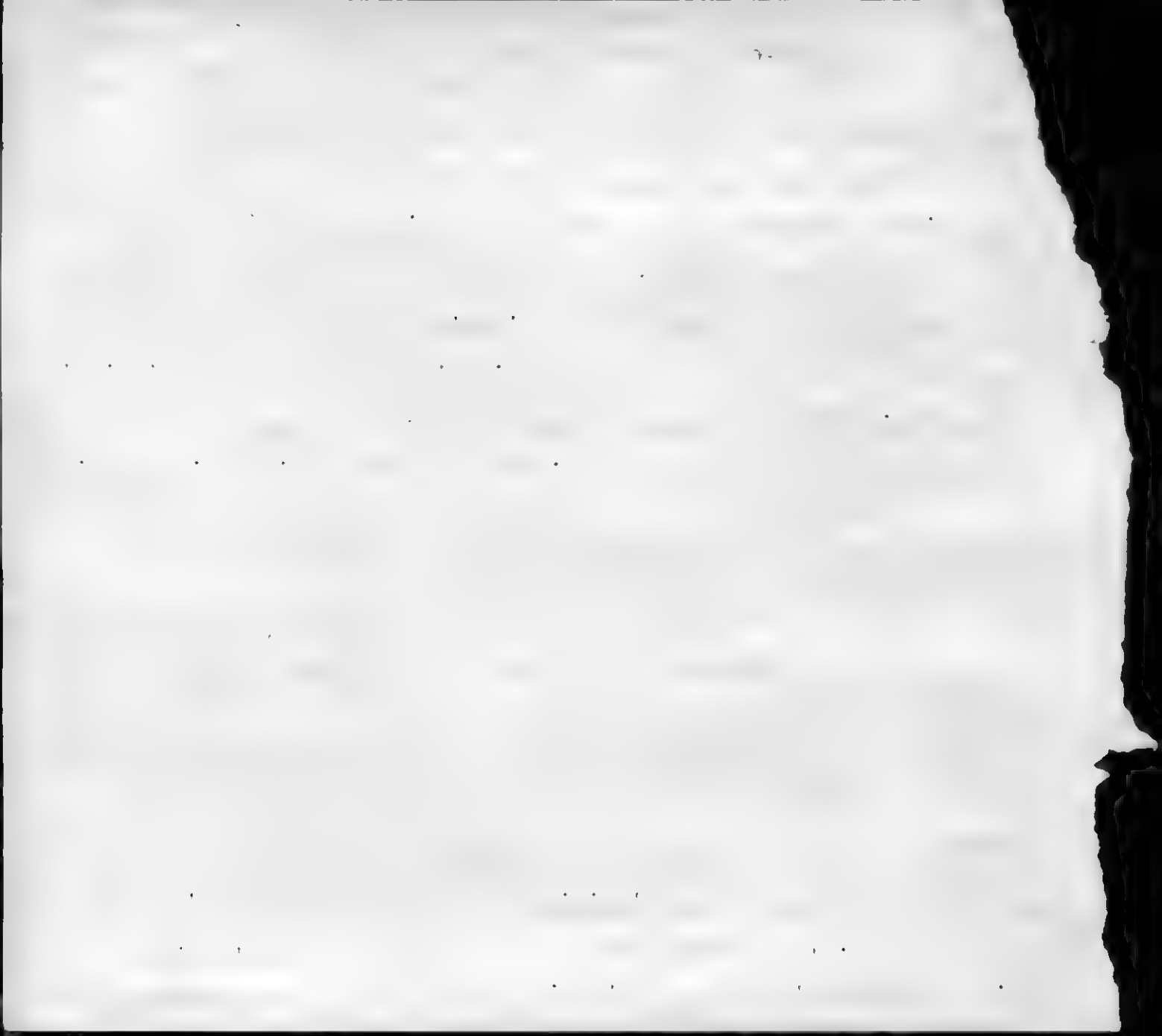
02730

Reg. Dist. No.

2735

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 16 So. Lee Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 16 So. Lee Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARIE Middle Alexandria Last HASLACKER				4. DATE OF DEATH Month March Day 31 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1880	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Abel A. Parks				14. MOTHER'S MAIDEN NAME Rebecca Judy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Anthony Haslacker, 16 S. Lee St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH sudden ----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u><i>Benedict Skitarelic</i></u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 31, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 3, 1960		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE APR 4 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>	

MEDICAL CERTIFICATION

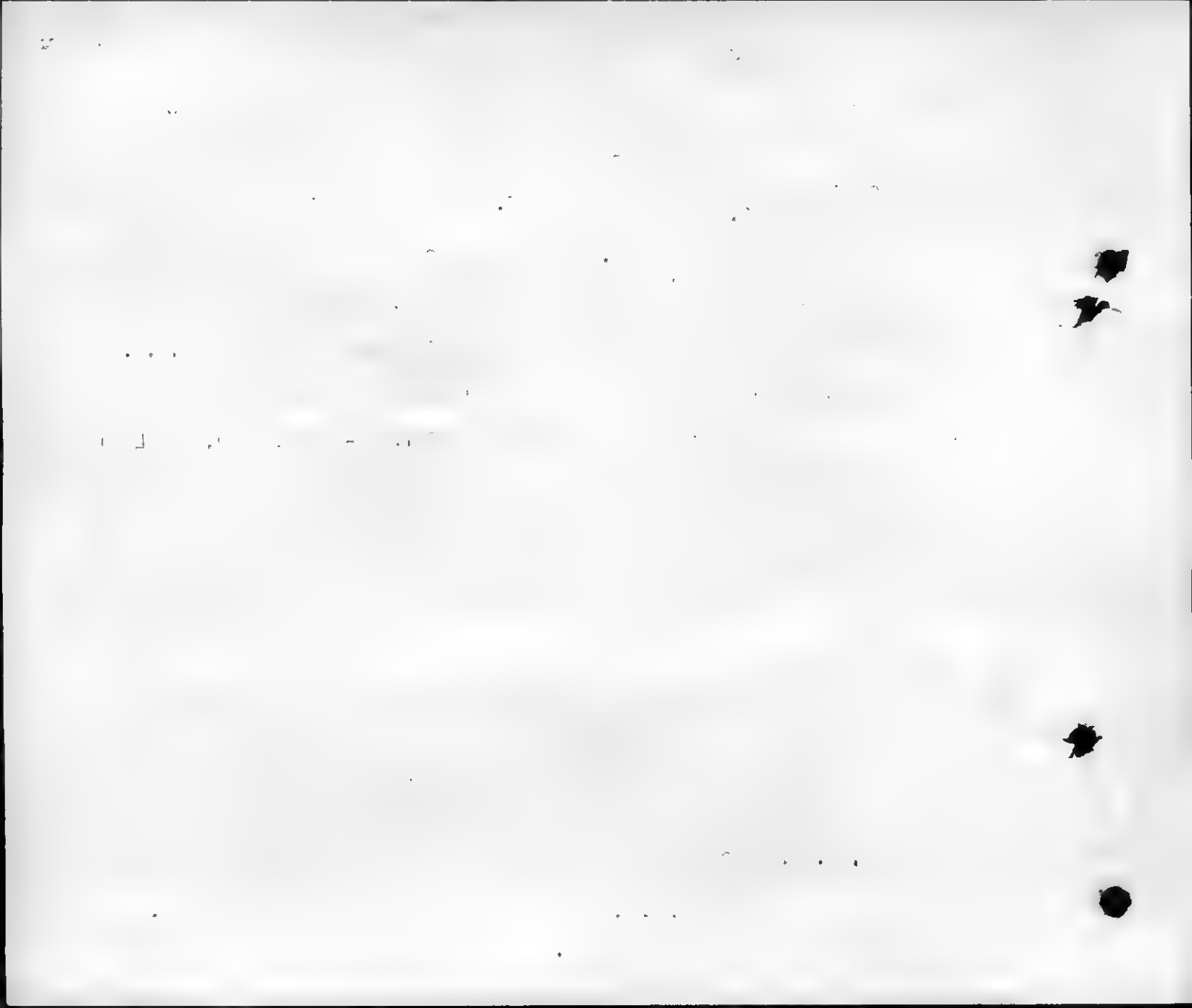


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02731

2736

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS RT. #3, BEDFORD ROAD			
3. NAME OF DECEASED (Type or print) First GRACE Middle W. Last HENDRICKSON				4. DATE OF DEATH Month MARCH Day 25 Year 1960			
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 22, 1881		9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WIGFIELD				14. MOTHER'S MAIDEN NAME VIRGINIA HARTSOCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Perforated Gallbladder 5-4-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cholecystitis & Cholelithiasis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5-d 10 y.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive & Atherosclerotic Cardiovascular Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 to 3/25, 1969 that (I) (we) last saw the deceased alive on 3/25, 1960 and that death occurred at 1:40 AM the causes and on the date stated above.							
22a. SIGNATURE Dr. S. G. Weisman				22b. DATE SIGNED 3/31/60		22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN	
22d. ADDRESS 59 Green St. Cumberland, Md							
23a. BURIAL CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 3/27/1960		23c. NAME OF CEMETERY OR CREMATORY P.O.S. of A. Cemetery		23d. LOCATION (City town or county) (State) Centreville, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE Apr 4 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			



2773

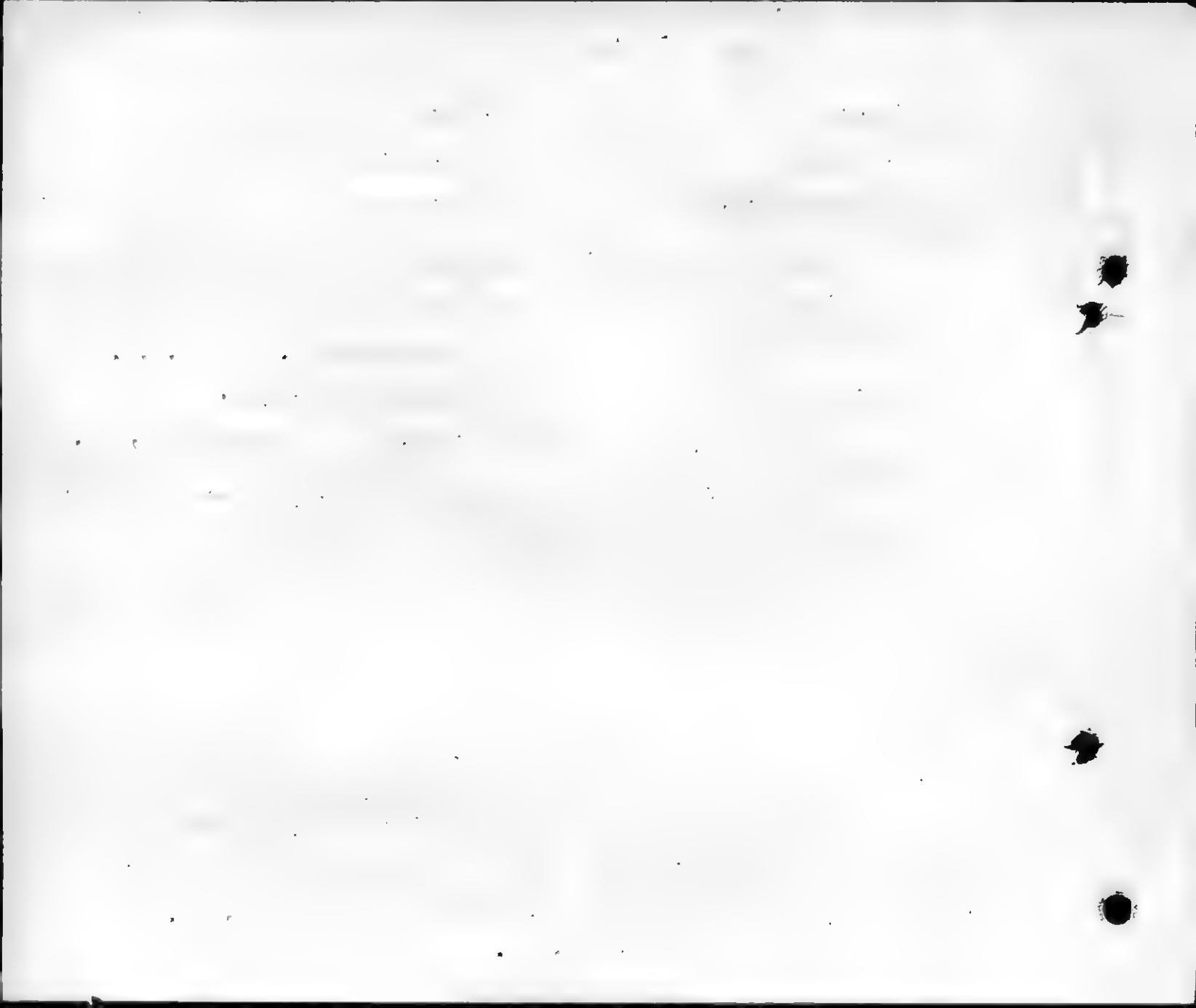
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing d. STREET ADDRESS Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATE Middle CLEMENTINE Last HERRON		4. DATE OF DEATH Month 3 Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/1887
9. AGE (In years lost birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Bell		14. MOTHER'S MAIDEN NAME Margaret Whitefield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
INFORMANT HENRY HERRON		Address Lonaconing, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Smoking DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAR 21 , 1960, to MAR 24 , 1960, that I last saw the deceased alive on MAR 24 , 1960, and that death occurred 10:30 A .M, from the causes and on the date stated above.			
ACTUAL SIGNATURE WOMC Lane		ADDRESS (Street, city or town, state) Frostburg MAR 24 1960	
PHYSICIAN'S NAME (Type) WOMC Lane		DATE SIGNED MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/1960	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		ADDRESS LONA CONING, MD.	
24a. REC'D BY REGISTRAR MAR 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. H. 1960	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



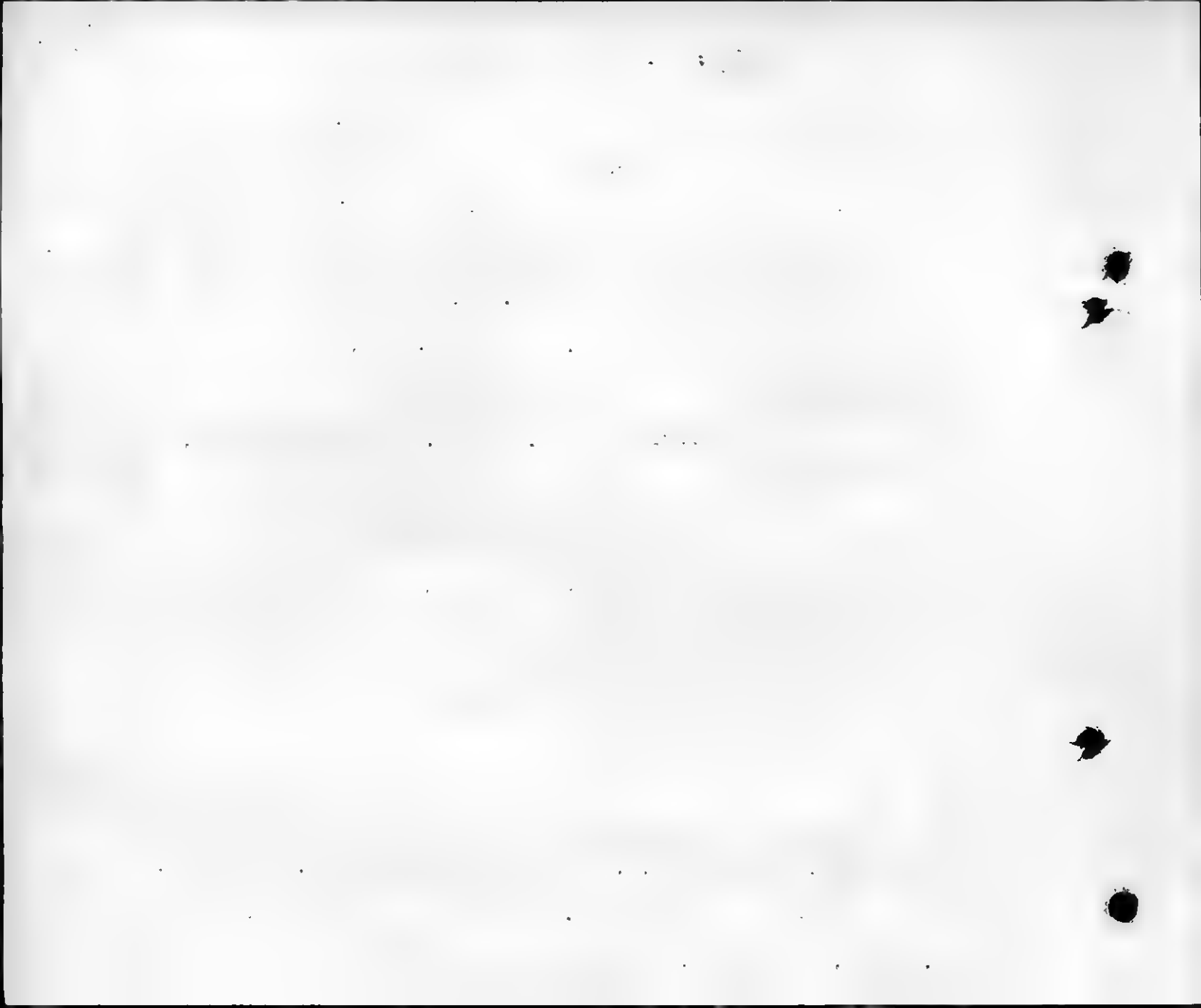
2737 **CERTIFICATE OF DEATH** 02733

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b years 02.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 120 Humbird Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT First HOPELL Middle Last		4. DATE OF DEATH March 11 Month Day Year 19 60	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1913
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY C & A GAS CO.	
11. BIRTHPLACE (State or foreign country) VALE SUMMIT, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT HOPELL		14. MOTHER'S MAIDEN NAME ANNIE HARRIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 214-05-7879	
17. INFORMANT Mrs. Mary K. Hobell		120 Humbird Street Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute left ventricular failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (b) Acute anterior myocardial infarction (c) Coronary arteriosclerosis, myocardial fibrosis			INTERVAL BETWEEN ONSET AND DEATH immediate 62 days ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 18 , 19 56 , to March 11 , 19 60 , that I last saw the deceased alive on but not 8 , 19 60 , and that death occurred at 1:25 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) %x 50 Pershing St. Cumberland, Maryland DATE SIGNED 3/14/60			
ACTUAL SIGNATURE Samuel M. Jacobson M.D.			
PHYSICIAN'S NAME (Type) SAMUEL M. JACOBSON, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/14/60	22c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR MAR 16 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



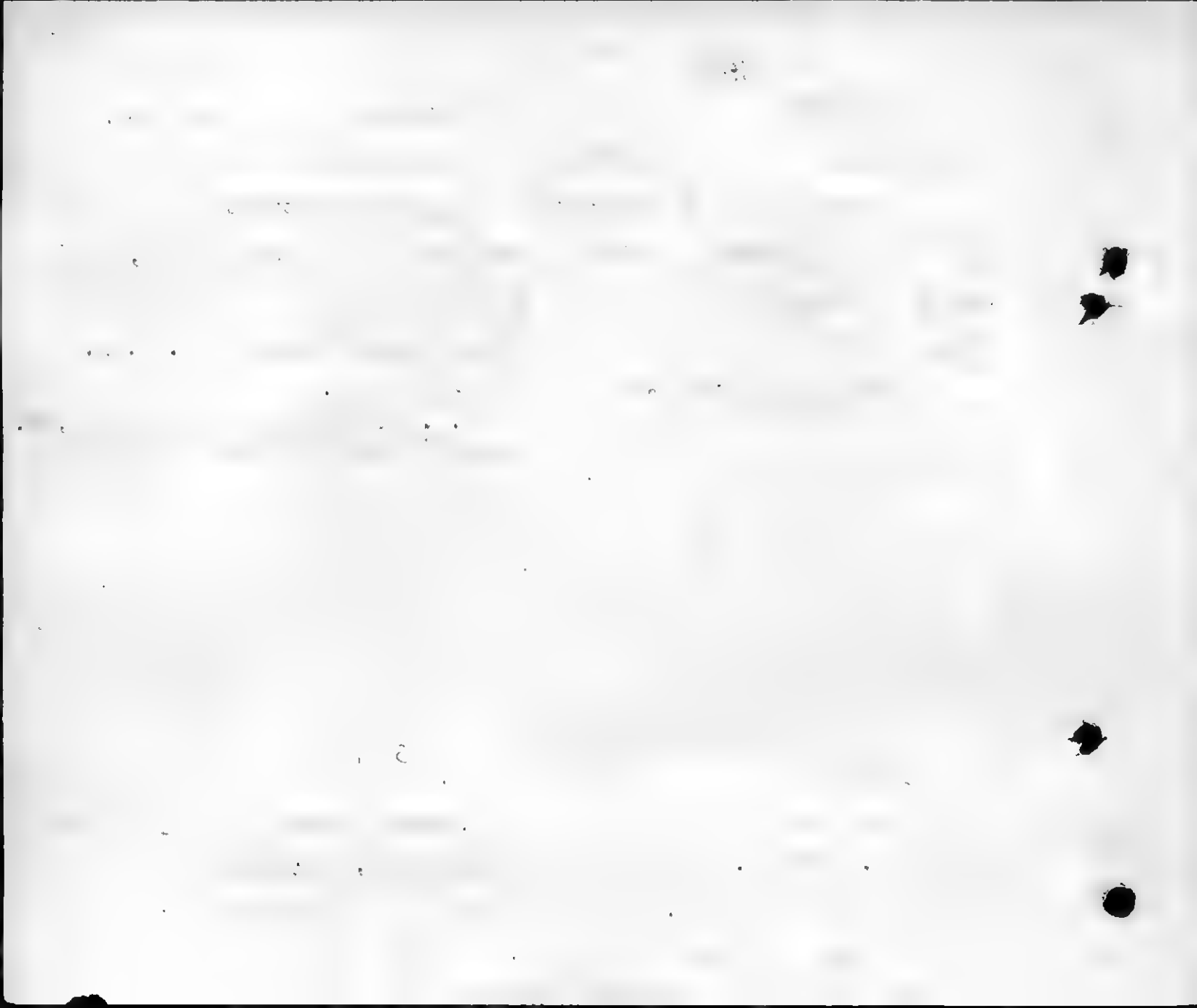
2738 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Allogany MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Allogany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 7/15/59	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allogany County Infirmary		e. STREET ADDRESS 401 Bealle Street	
3. NAME OF DECEASED (Type or print) First Jessie Middle Viola Last Hoonicka		4. DATE OF DEATH Month March Day 17 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/10/1881
9. AGE (In years (last birthday) yrs) 78		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Christopher Hoonicka		14. MOTHER'S MAIDEN NAME Sophia Hess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO None	
INFORMANT P.O.Box 599 Address Cumberland, Md.		Allogany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Hypertosis. 40 . 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic myocarditis DUE TO (c) Severe arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 36 hrs. ? ?
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic nephritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/15/59 , 19____, to 3/17/60 , 19____, that I last saw the deceased alive on 3/16/60 , 19____, and that death occurred at 7:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 3/17/60			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS 49 Greene Street DATE SIGNED 3/17/60	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		CUMBERLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar 19 1960	22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		ADDRESS Cumberland Md.	24a. REC'D BY REGISTRAR DATE MAR 21 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2779

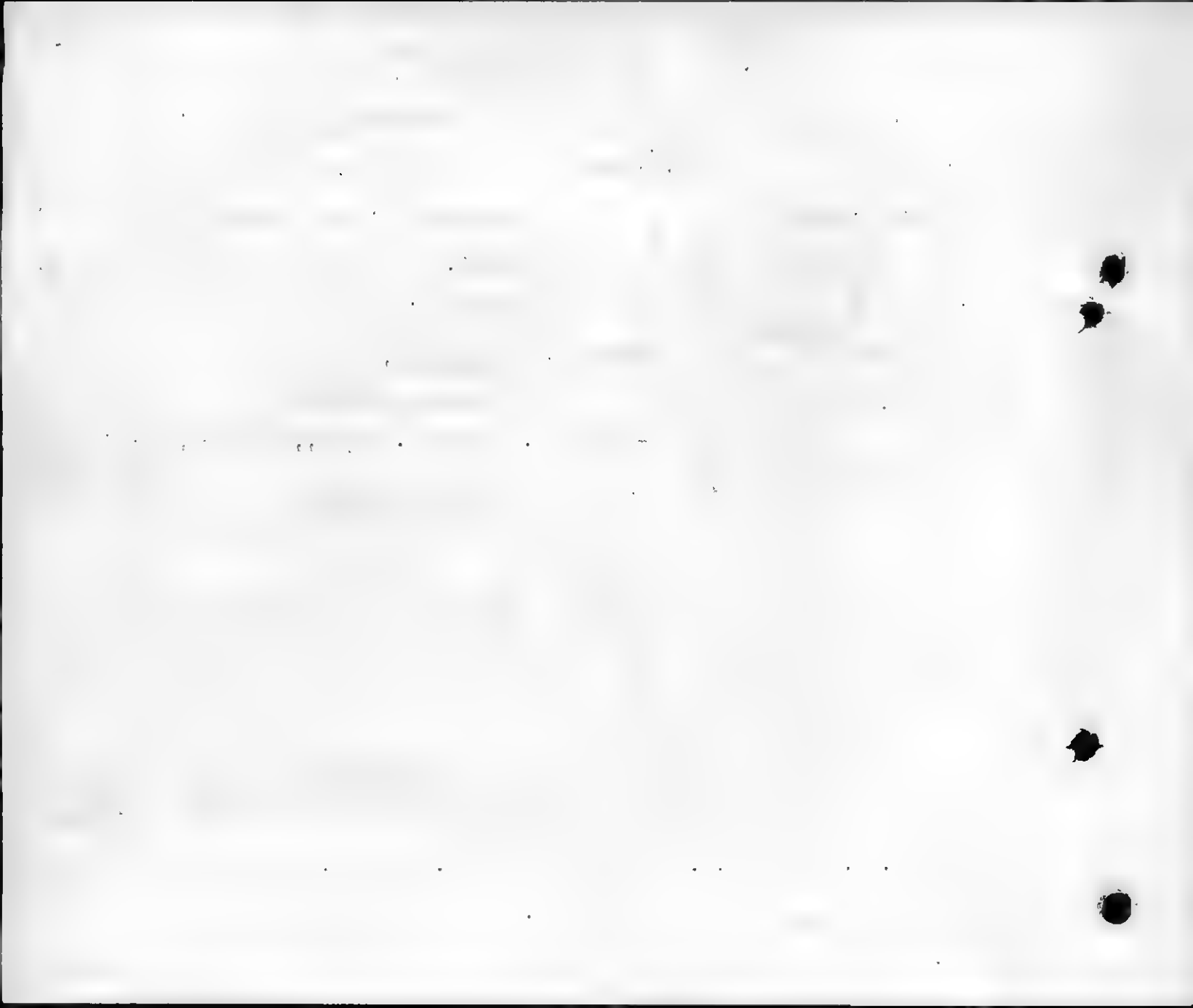
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES WALTER HUNTER, JR.		4. DATE OF DEATH March 3 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 26, 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		11. BIRTHPLACE (State or foreign country) Frostburg, Maryland	
13. FATHER'S NAME WILLIAM C. HUNTER		14. MOTHER'S MAIDEN NAME HENRIETTA MICHAEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-30-0784	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15 1960 to Mar 3 1960 , that I last saw the deceased alive on Jan 15 1960 , and that death occurred at 9:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W O McLane		DATE SIGNED Mar 4 1960	
PHYSICIAN'S NAME (Type) W. O. McLane M.D.		167 W. Main St. Frostburg, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/6/60	22c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park	22d. LOCATION (City, town, or county) (State) Frostburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. HAFFER, CUMBERLAND, MARYLAND		24a. REC'D BY REGISTRAR MAR 10 1960	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and complete page 1 and 2 should be filled with the name of the deceased, the date of death, and the cause of death. Then please remove carbon page 3 should be detached for use at the burial-transit permit. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the State Board of Health requires that the certificate be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the State Board of Health.

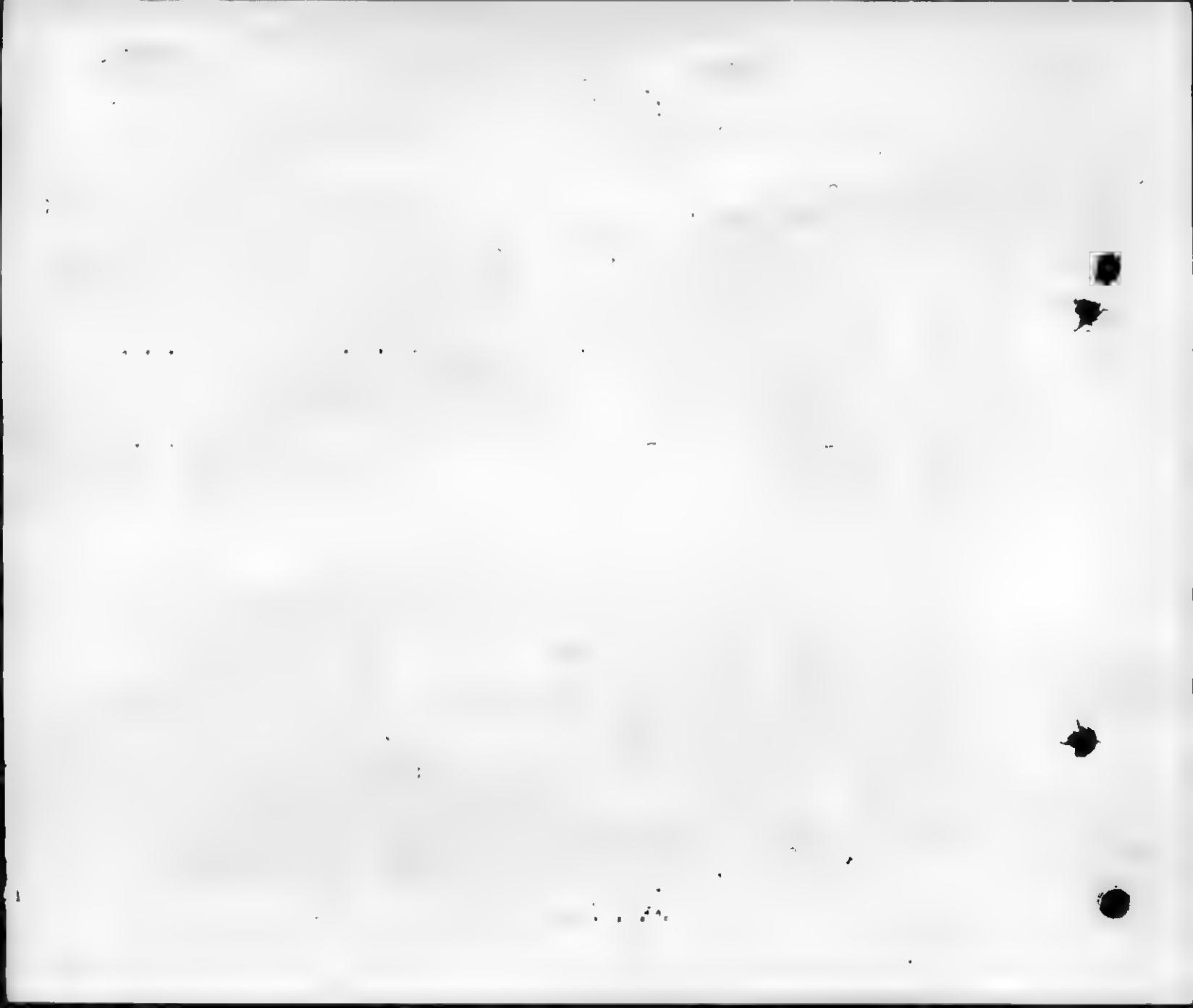
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2739

CERTIFICATE OF DEATH

04023

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
c. LENGTH OF STAY IN 1b 8 DAYS				d. STREET ADDRESS 532 BROADWAY CIRCLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WARREN Middle B. Last HYSON				4. DATE OF DEATH Month MARCH Day 31 Year 1960			
5 SEX MALE		6 COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 2, 1912	
9 AGE (In years last birthday) 47 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Railway postal clerk				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ELKINS, W.VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WINFIELD HYSON				14. MOTHER'S MAIDEN NAME MARTHA HELMICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16 SOCIAL SECURITY NO. 1934-1937		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Myocardial Infarction							
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 3/23 19 60 to 3/31 19 60 , that (I) (we) last saw the deceased alive on 3/31 19 60 and that death occurred at 6:50 PM from the causes and on the date stated above.							
22a. SIGNATURE <i>Les H. Weisman</i>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 4/6/60	
22c. PHYSICIAN'S NAME (Type) DR. WEISMAN				22d. ADDRESS 450 N. Centre St., Cumberland Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/3/60		23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		23d. LOCATION (City, town, or county) (State) Elkins West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				25a. REC'D BY REGISTRAR Cumberland Maryland		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kinn</i>	



2740

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2/3/1954	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Angus Middle J. Last Ireland		4. DATE OF DEATH Month March Day 4 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/23/1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supt. Mails at U.S. Customs		10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Walter Ireland		14. MOTHER'S MAIDEN NAME Martha Lumsden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT P. O. Box 599 Address Cumberland, Md.		18. ALLEGANY COUNTY INFIRMARY RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial degeneration 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral arteriosclerosis DUE TO (c) Senile deterioration		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/3/54 , 19 54 , to 3/4/60 , 19 60 , that I last saw the deceased alive on 3/4/60 , 19 60 , and that death occurred at 7:05 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 4/5/60			
ACTUAL SIGNATURE James E. McLean M.D.		PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE MAR 8 '60	
24b. REGISTRAR'S SIGNATURE Charles E. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

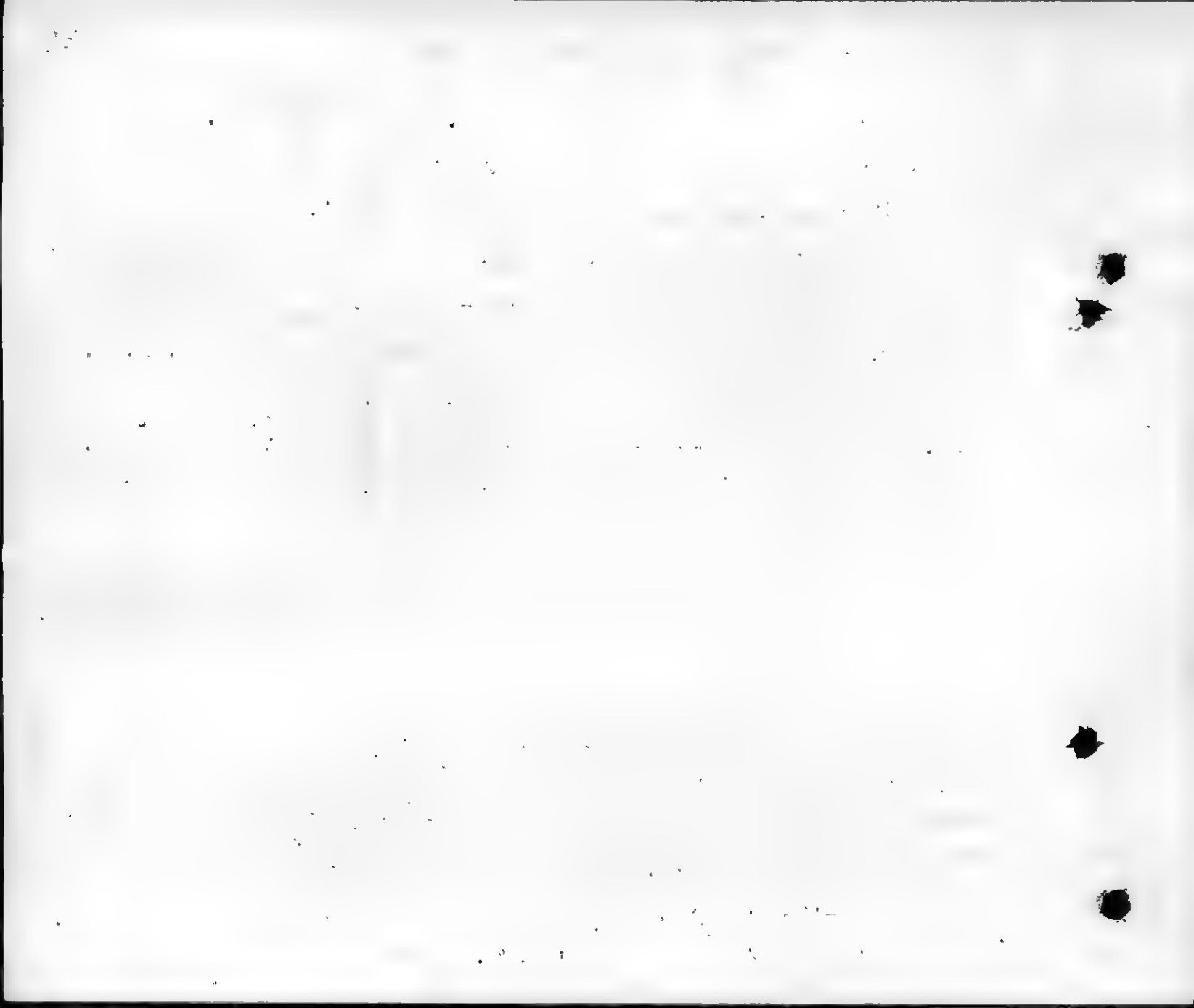
2780

CERTIFICATE OF DEATH

02737

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 33 Linden Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle F. Last Jackson				4. DATE OF DEATH Month 3 Day 13 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-24-1880		9. AGE (In years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months 7 Days 9 Hours 13 Min. 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Coal Miner		11. BIRTHPLACE (State or foreign country) Midland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Jackson				14. MOTHER'S MAIDEN NAME Sarah Cavanaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. 236-14-8122			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 hrs DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 10 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAR 13, 1960 , to MAR 13, 1960 that I last saw the deceased alive on MAR 13, 1960 , and that death occurred at 3:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE WOMC Lane M.D.				ADDRESS (Street, city or town, state) Frostburg Md. DATE SIGNED MAR 14 1960			
PHYSICIAN'S NAME (Type) WOMC Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-1960		22c. NAME OF CEMETERY OR CREMATORY St. Michaels's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul D. Dillinger				24a. REC'D BY REGISTRAR MAR 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



2741 CERTIFICATE OF DEATH

Reg. Dist. No.

02738

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN lb <u>15 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. STREET ADDRESS <u>McKay Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>James</u> Last <u>Kamauf</u>				4. DATE OF DEATH <u>3/25/60</u> Month <u>3</u> Day <u>25</u> Year <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/86</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland, Eckhart</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adam Kamauf</u>				14. MOTHER'S MAIDEN NAME <u>Anna Ratigan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-07-5749</u>		INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>400.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat. while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-15-1957</u> to <u>3-15-1960</u> , that I last saw the deceased alive on <u>3-15-1960</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>3.26/60</u>							
ACTUAL SIGNATURE <u>L. Brings</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. L. Brings</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Ambrose Cath. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cresaptown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAR 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kneel</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

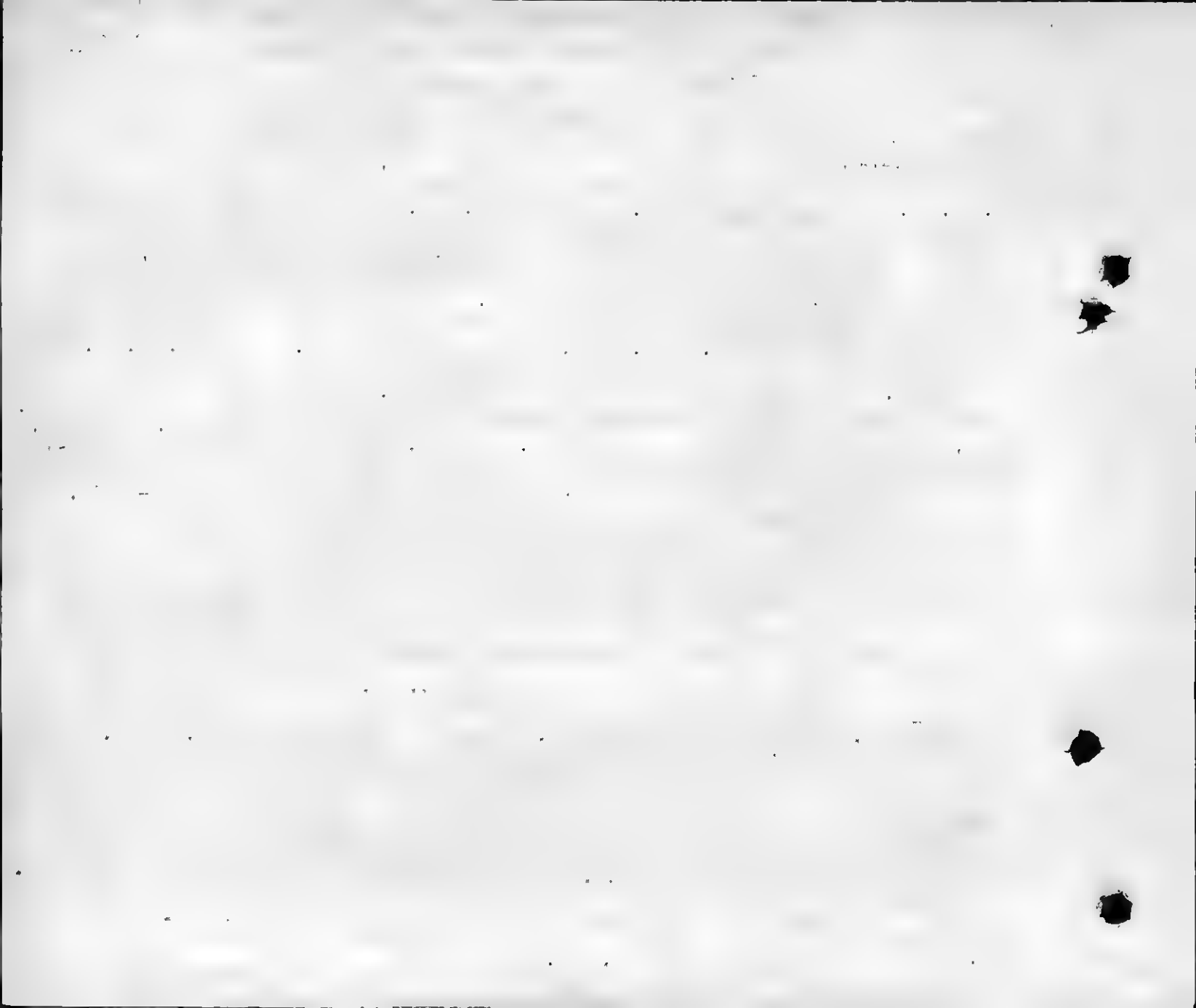
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02739

1. PLACE OF DEATH a. COUNTY Allegany 2742 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Sacred Heart Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings, d. STREET ADDRESS Nr. Rt. # 220 at Rawlings, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Theodore Middle Ellsworth Last Kasecamp		4. DATE OF DEATH Month March Day 28 , Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1881
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78	IF UNDER 24 HRS. Hours 78 Min 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	
11. BIRTHPLACE (State or foreign country) Green Ridge, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John M. Kasecamp		14. MOTHER'S MAIDEN NAME Nettie L. Stott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. Address Mt. Rainier, Md. Mrs. Mary F. Lechlitter 3701 Perry St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of neck (2nd Cervical) DUE TO Struck by Auto Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Struck by Auto DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PR. MARY, or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by auto at Rawling, Md. Rt. 220	
20c. TIME OF INJURY Month, Day, Year Hour 7:00 P. m. Mar. 28 1960		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. # 220		20f. (City or town) (County) (State) Rawlings, Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/>. and find that death resulted from: Natural causes <input type="checkbox"/>. Accident <input checked="" type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE <i>Benedict Skitarelis</i> NAME (Type) Benedict Skitarelis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 28, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/60	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		24a. REC'D BY REGISTRAR DATE APR 1 '60	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE <i>Charles S. Hanks</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 18. Page 1 may be retained for your files. GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



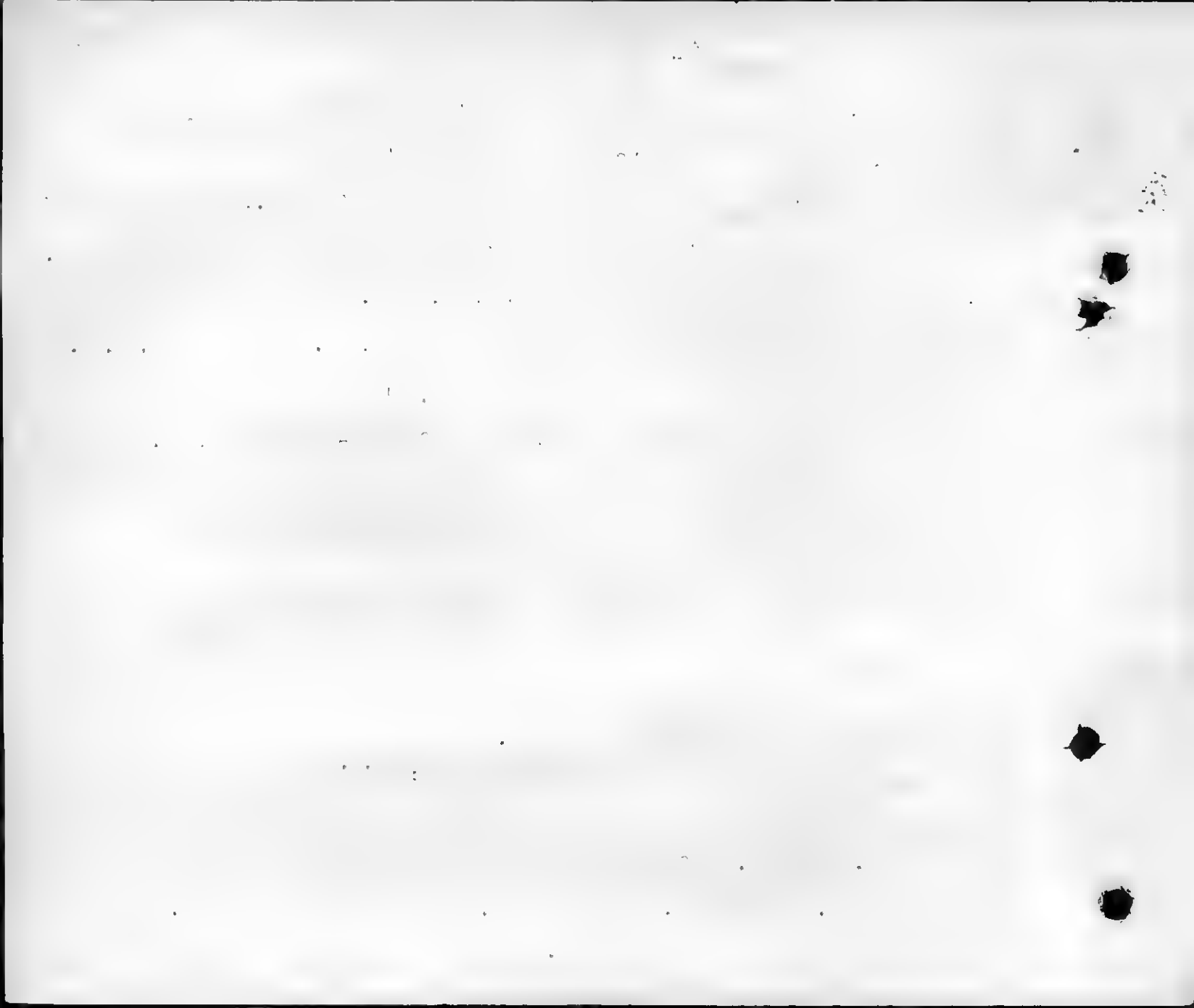
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02740

2743

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 239 HENDERSON AVE., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY GIRL (A) First BABY GIRL (A) Middle KELLER Last KELLER		4. DATE OF DEATH Month MARCH Day 22 Year 1960.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 20, 1960.
9. AGE (In years lost birthday) yrs 2		10. IF UNDER 1 YEAR: Months 2 Days 2 Hours 37	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MD.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE KELLER		14. MOTHER'S MAIDEN NAME MARY M. O'ROURKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Immaturity of vital structures DUE TO (c) Sec'd		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 20 March 1960 , 19____, that (I) (we) last saw the deceased alive on 22 March 1960 , and that death occurred at 6:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Leland B. Ransom		22b. DATE SIGNED 23 March 60	
22c. PHYSICIAN'S NAME (Type) DR. LELAND B. RANSOM		22d. ADDRESS 63 Greene St. Cumberland, Md	
23a. BURIAL CREMATION BURIAL	23b. DATE THEREOF MAR. 23, 1960	23c. NAME OF CEMETERY OR CREMATORY ST. PATRICKS CEM.	23d. LOCATION (City, town, or county) (State) CUMBERLAND, MD.
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT		25a. REC'D BY REGISTRAR MAR 28 '60	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE C. H. S. Kline	

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may be retained by the hospital, or attending physician.
TOTAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon paper and file in the State Board of Health.

2744

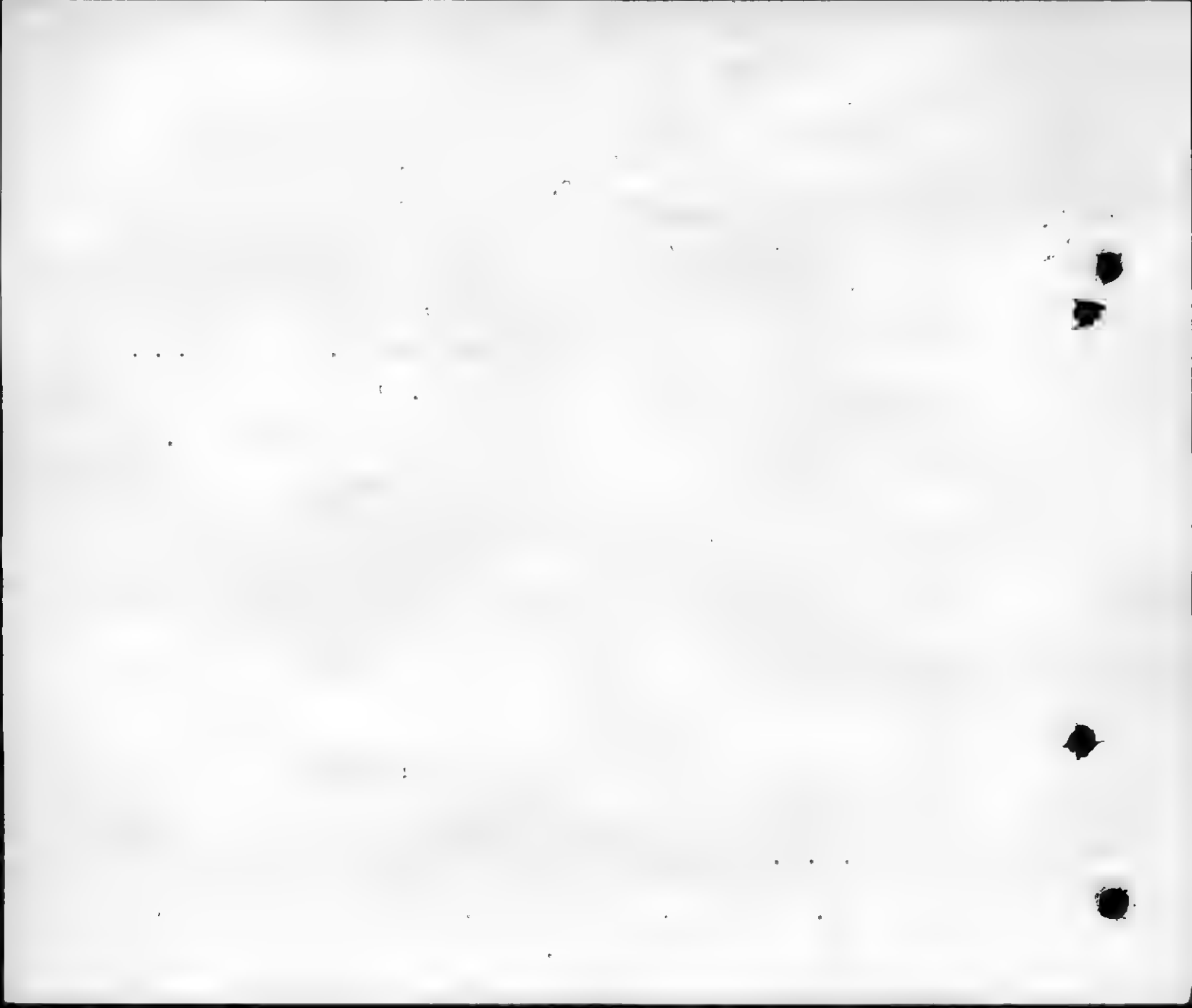
2744

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02741

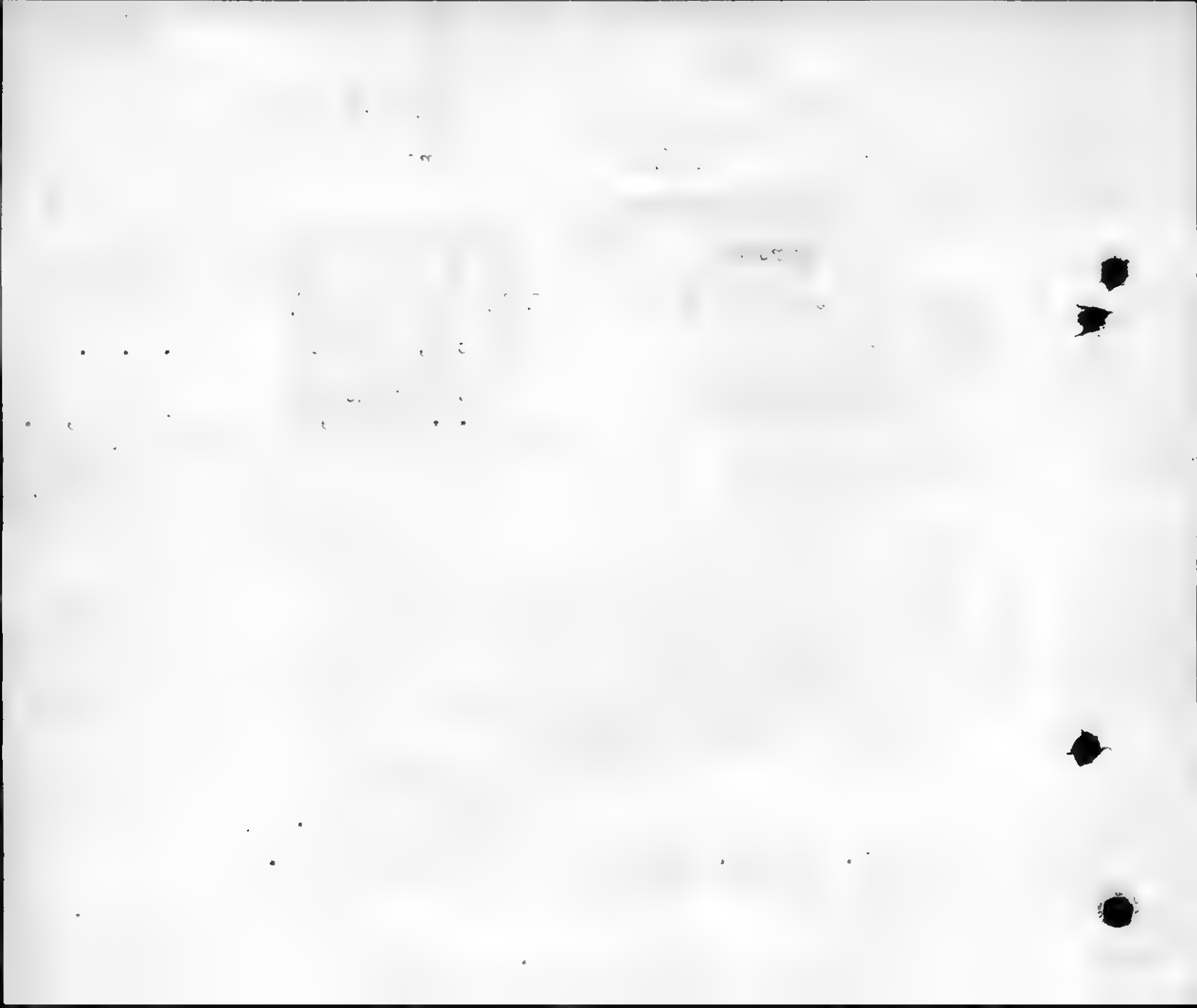
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, d. STREET ADDRESS 239 HENDERSON AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY BOY (B) Middle KELLER Last KELLER		4. DATE OF DEATH Month MARCH Day 22 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 20, 1960
9. AGE (In years lost birthday) yrs 1 Months 1 Days 10 Hours 24 Min 24		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE KELLER		14. MOTHER'S MAIDEN NAME MARY M. O'ROURKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Spontaneous Pneumothorax Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Immaturity of vital Structures DUE TO (c) Immaturity of vital Structures PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 20 March 1960 to 21 March 1960 , that (I) (we) last saw the deceased alive on 21 March 1960 , and that death occurred at 2:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Leland B. Ransom M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. L. B. RANSOM		22d. ADDRESS 63 Green St., Cumberland, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAR. 23, 1960	23c. NAME OF CEMETERY OR CREMATORY ST. PATRICKS CEMETERY	23d. LOCATION (City, town, or county) (State) CUMBERLAND, MD.
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR MAR 28 '60 DATE	
		25b. REGISTRAR'S SIGNATURE Cedric S. Kneass	

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02742

VS A15 (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

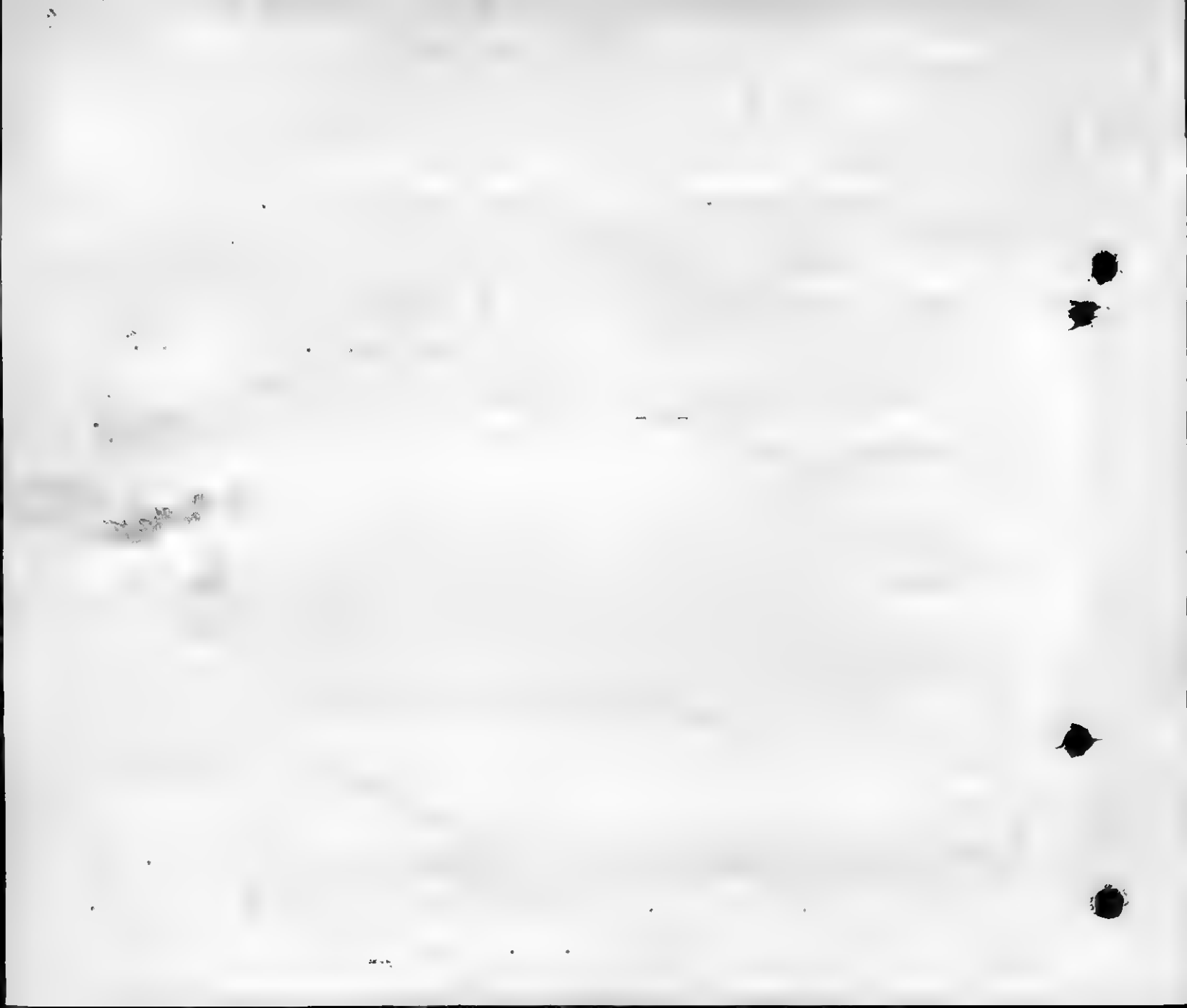
2789

CERTIFICATE OF DEATH

02743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTERNPORT				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTERNPORT			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARYLAND AVE.				/d. STREET ADDRESS 300 MARYLAND AVE.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First OWEN Middle JOSEPH Last KELLY		4. DATE OF DEATH Month MAR Day 31 Year 60		5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 18, 1901		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PIEDMONT, W. VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOHN J. KELLY		14. MOTHER'S MAIDEN NAME CATHERINE GARRETT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 214-10-5189		17. INFORMANT GENEVIEVE KELLY, 300 Maryland Ave. Westernport, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) Coronary Embolus 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Myocarditis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 minutes 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 10, 1958 , to March 31, 1960 , that I last saw the deceased alive on Feb. 26, 1960 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul R. Wilson				ADDRESS (Street, city or town, state) M.D. Ashfield St. Piedmont, W. Va.			
DATE SIGNED 4-2-60							
PHYSICIAN'S NAME (Type) PAUL R. WILSON				ASHFIELD ST. PIEDMONT, WVA.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APR. 4, 60		22c. NAME OF CEMETERY OR CREMATORY ST. PETERS CEMETERY		22d. LOCATION (City, town, or county) (State) WESTERNPORT MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Fredlock				ADDRESS PIEDMONT, W. VA.		24a. REC'D BY REGISTRAR DATE APR 4 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

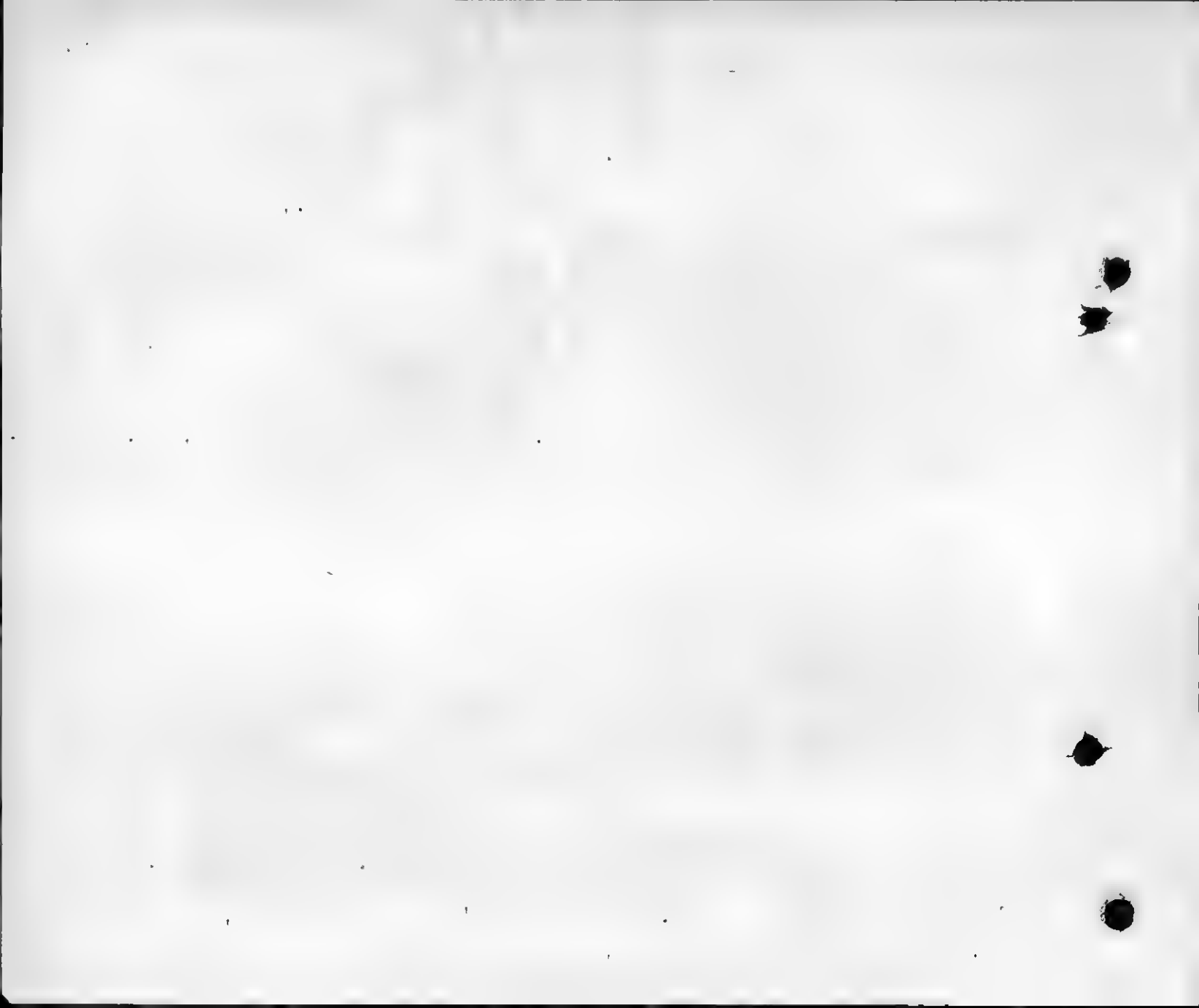


CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c LENGTH OF STAY IN TB 11 yrs 6 mo. 16 da	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		d STREET ADDRESS 714 Columbia Ave.,	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Nellie Middle Bernadette Last Kienhofer		4. DATE OF DEATH Month March Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1887
9. AGE (In years last birthday) yrs 72		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Edward Kelly	
14 MOTHER'S MAIDEN NAME Pauline Jesse		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO None		17. INFORMANT Address 605 Fairview Ave. Mrs. James Cordry Cumberland, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 522 Pulmonary Congestion DUE TO (b) 193 Malignant neoplasm brain DUE TO (c) 450 General arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 304 Senile psychosis			INTERVAL BETWEEN ONSET AND DEATH 48 hrs. ? ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 1st, 1952 , to Mar. 16th 1960 , that I last saw the deceased alive on Mar. 15th, 1960 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St., DATE SIGNED 3-17-60	
PHYSICIAN'S NAME (Type) James E. McLean, M.D.		49 Greene St., Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/18/60	22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE MAR 21 '60	24b. REGISTRAR'S SIGNATURE Orin L. Hume

MEDICAL CERTIFICATION



may be retained by the hospital or attending physician. GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with

Item 4 Film 260 4-5-60 et

2797

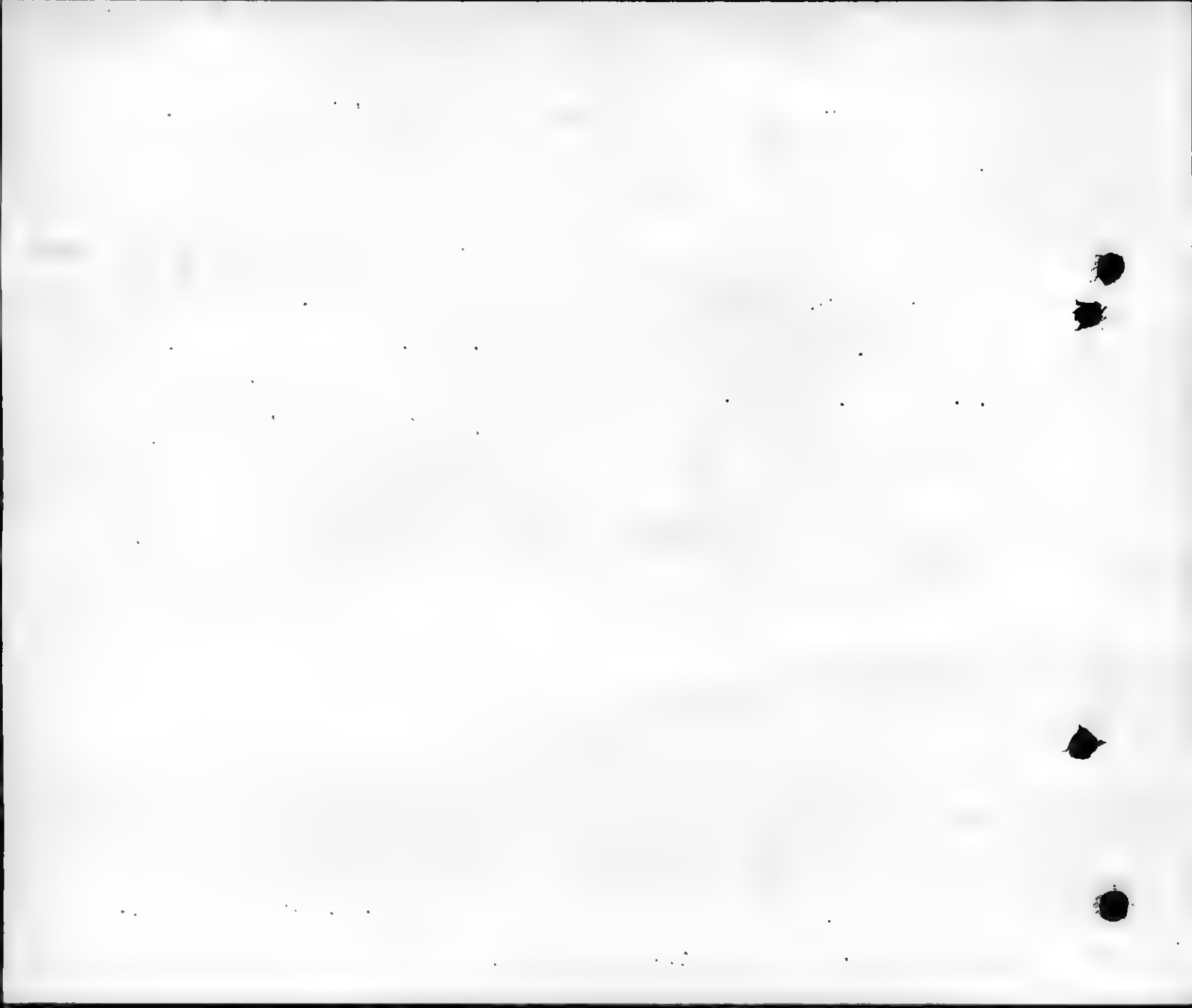
Item 4 Film 260 4-5-60 et

CERTIFICATE OF DEATH

02745

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAVALE MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JENNINGS, MD	
c. LENGTH OF STAY IN 1b 4 Mo.		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSA Middle A. Last LAYMAN		4. DATE OF DEATH March 22, 1960	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 3, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) HARMON, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY CUNNINGHAM		14. MOTHER'S MAIDEN NAME CAROLINE BLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Mrs. Ethel Lehty, LaVale, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Carcinomatous, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, uterus (c)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-25 , 19 56 to 3-22 , 19 60 that I last saw the deceased alive on March 5 , 19 60 , and that death occurred at 6:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Alexander Solosko M.D.		ADDRESS (Street, city or town, state) Solidsburg Pa DATE SIGNED 3/23/60	
PHYSICIAN'S NAME (Type) Alexander Solosko, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/25/60	
22c. NAME OF CEMETERY OR CREMATORY MT ZION		22d. LOCATION (City, town, or county) (State) STAR ROUTE FROSTBURG GARRETT Co MD	
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman, Grantsville, Md		24a. REC'D BY REGISTRAR MAR 28 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Knead	



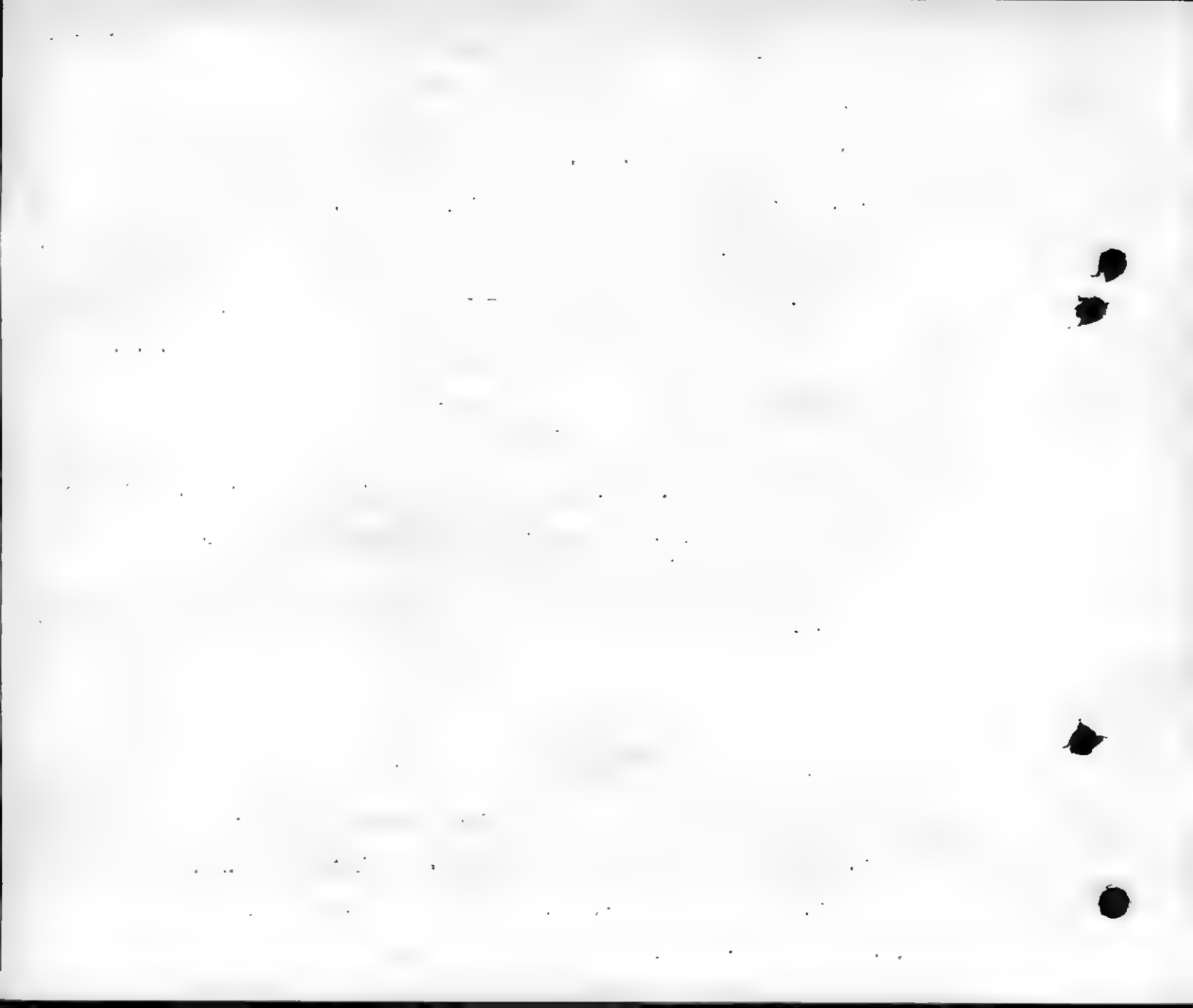
2747 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN TB 111 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 8 Klosterman Addition		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eunnie Middle Lazarus Last Lazarus				4. DATE OF DEATH Month 3 Day 26 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-7-85	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 14 Hours 14 Min.		11. IF UNDER 24 HRS Months 7 Days 14 Hours 14 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) England, Manchester	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Sapito				14. MOTHER'S MAIDEN NAME Sophia Mekalevitch			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		INFORMANT Patients Chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Circulatory Collapse and Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the Caecum with hepatic and pelvic metastases DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 18 hours 8 months(?)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 12th 1959 , to March 26th, 1960 that I last saw the deceased alive on March 26th, 1960 and that death occurred at 1:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Algonquin Hotel Building, Cumberland, Md. DATE SIGNED 3/28/60							
ACTUAL SIGNATURE W. J. Doerner		M.D. Algonquin Hotel Building, Cumberland, Md.					
PHYSICIAN'S NAME (Type) Jr. W. Doerner							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/60		22c. NAME OF CEMETERY OR CREMATORY East View Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE 3 0 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

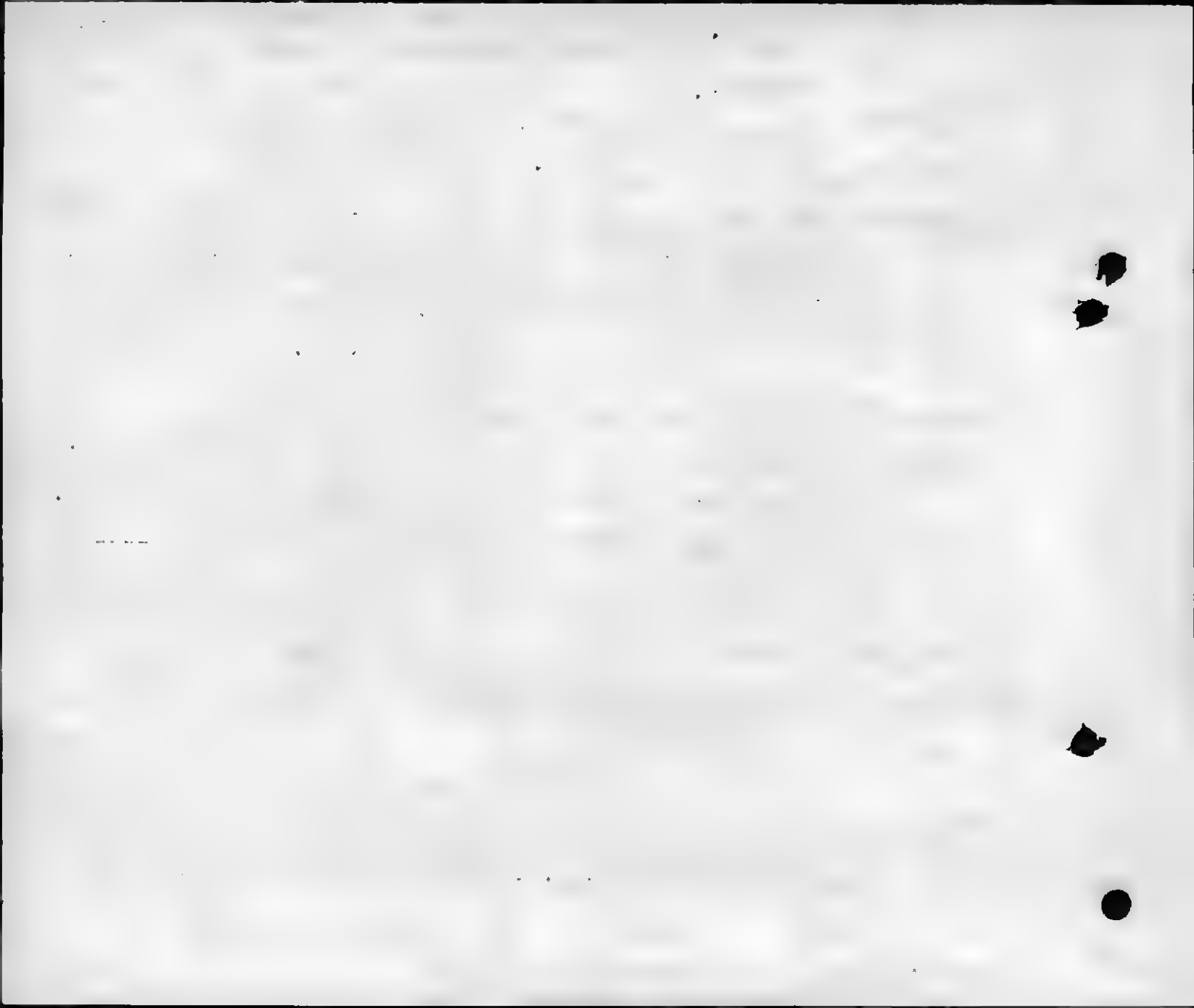
02747

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany 2743 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 317 Emily Street d. STREET ADDRESS Cumberland, Maryland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MYRTLE Middle J. Last LEA				4. DATE OF DEATH Month March Day 12 Year 19 60					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 21, 1891		9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Eagle Rock, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Linkenhoker				14. MOTHER'S MAIDEN NAME Lucy Merritt					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Memorial Hospital Address Cumberland, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation, Pulmonary Edema DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic cardiovascular disease DUE TO (c) ----								INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED March 12, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/60		22c. NAME OF CEMETERY OR CREMATORY Eagle Rock Cemetery		22d. LOCATION (City, town, or county) Eagle Rock (State) Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Ruth F. Silcox				24a. REC'D BY REGISTRAR MAR 16 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02748

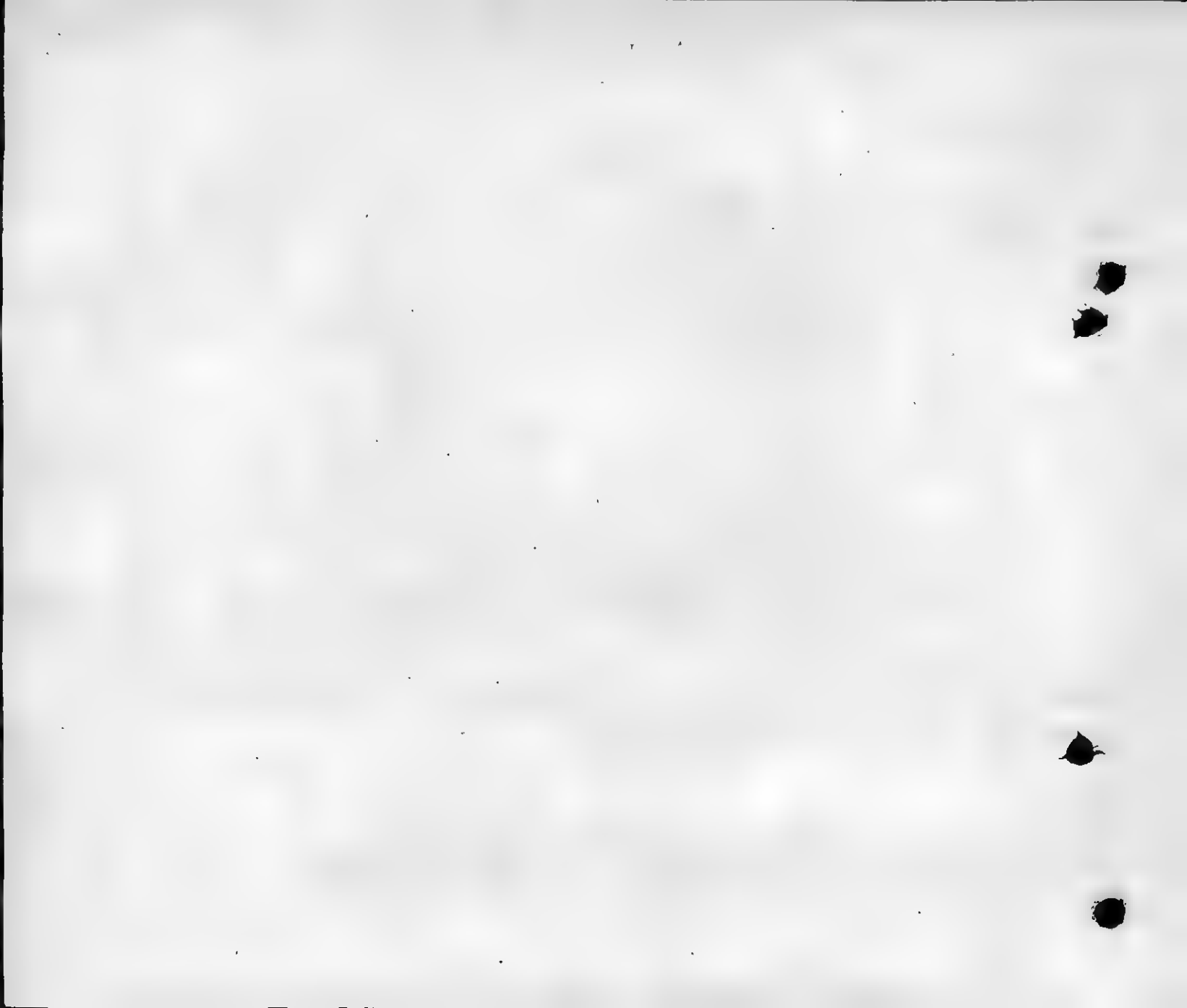
2781

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frostburg</i>		c. LENGTH OF STAY IN TB <i>15 Days</i> X <i>Ocean</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Miners Hospital</i>		d. STREET ADDRESS <i>RT #1 Frostburg</i>	
3. NAME OF DECEASED (Type or print) <i>Rose Lease</i>		4. DATE OF DEATH <i>Mar 25 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 2 1887</i>
9. AGE (in years last birthday) <i>72</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Henry Lark</i>		14. MOTHER'S MAIDEN NAME <i>Phoebe Brewer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Henry Lease</i>		Address <i>Germanstown, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Vascular Renal Disease</i> <i>932.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Malnutrition</i> (a), stating the underlying cause last, (c) <i>Frozen Fingers & Toes - Exposure</i> INTERVAL BETWEEN ONSET AND DEATH <i>15 Days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Found in home after 30 days without heat</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>Mar 10 1960</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. CITY OR TOWN (County) (State) <i>Ocean Allegany Md</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>W O McLane</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>W O McLane MD out</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/28/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Ashby Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Fort Ashby, W. Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George Cuckhorn</i>		24a. REC'D BY REGISTRAR <i>MAR 30 '60</i>	
ADDRESS <i>Louisa, Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanks</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, is designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

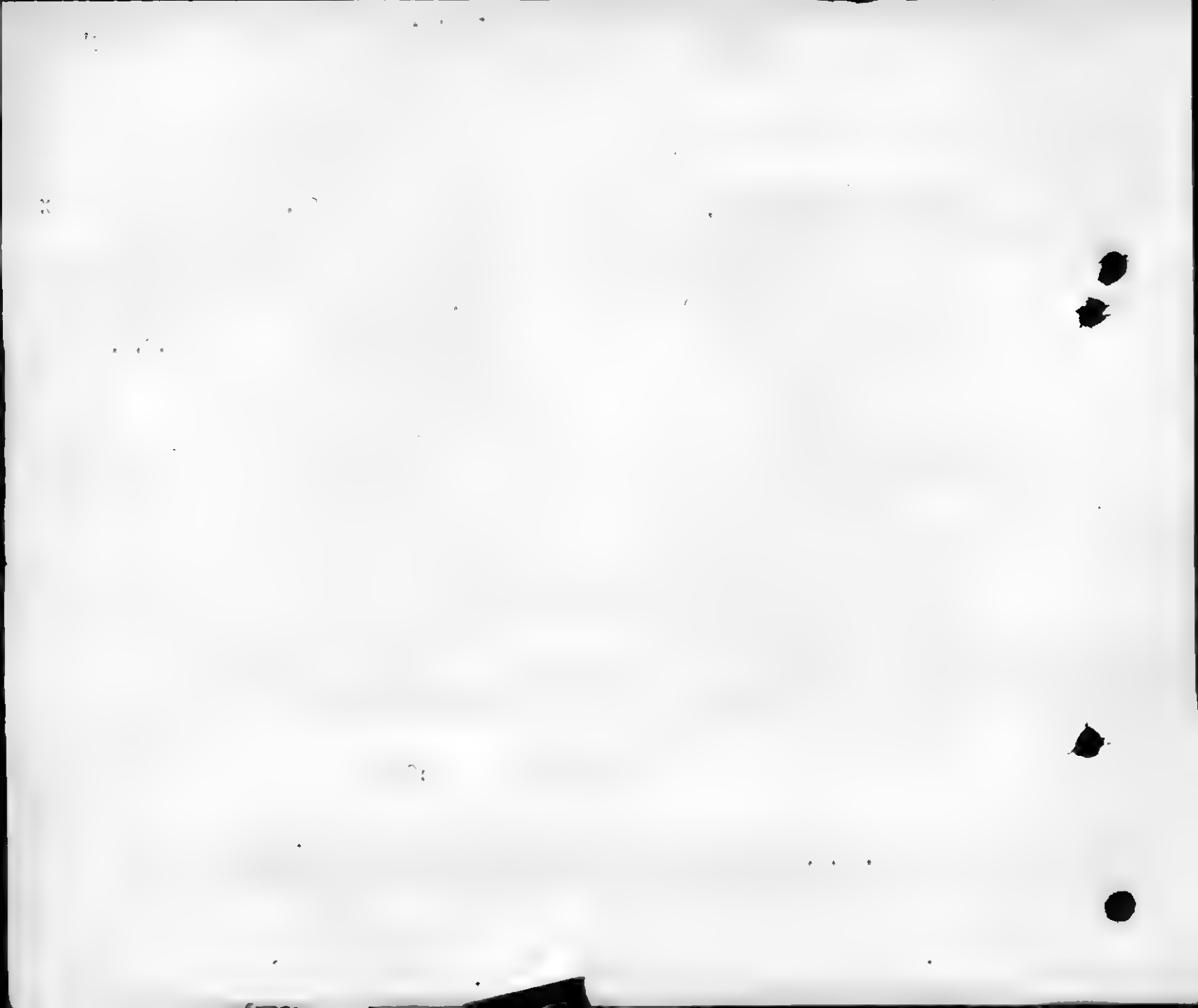


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2749 CERTIFICATE OF DEATH

02749

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 1809 BEDFORD ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle LESTER Last LESTER				4. DATE OF DEATH Month MARCH Day 23 Year 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 1, 1884		9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM BEATTY				14. MOTHER'S MAIDEN NAME MARY KITCHEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage with Left Hemiplegia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive and arteriosclerotic cardiovascular disease DUE TO (c) Gen. arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 20 Nov 1960 to 23 Nov 1960 , that (I) (we) lost the deceased alive on 23 Nov 1960 and that death occurred 5:25 PM from the causes and on the date stated above.							
22a. SIGNATURE W. Alfred Van Ormer				M. D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. W.A. VAN ORMER				22d. ADDRESS 122 S. Centre St Cumberland, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/26/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City town, or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox Cumberland Maryland				25a. REC'D BY REGISTRAR DATE MAR 29 '60		25b. REGISTRAR'S SIGNATURE Guthrie S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the State Board of Health will issue a permit for burial, cremation, or removal, and in any event, within 72 hours after death. This permit should be detached for use as the burial-transit permit. Then please remove carbon parts 1 and 2 should be filled with the name of the funeral director. Part 3 should be detached for use as the burial-transit permit. Then please remove carbon parts 1 and 2 should be filled with the name of the funeral director.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Ch of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2798 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02750

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellerslie</u>		c. LENGTH OF STAY IN 1b <u>45 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellerslie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>/</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Oscar H. Leydig</u>			4. DATE OF DEATH Month Day Year <u>March 17, 1930</u> <u>19</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10, 1888</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna. Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Bedford Co., Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Winfield Scott Leydig</u>		
14. MOTHER'S MAIDEN NAME <u>Sara Ellen Corley</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>716-10-6693</u>			17. INFORMANT Address <u>Mrs. Bertie Leydig, Ellerslie, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis</u> (c) DUE TO <u>Coronary Sclerosis</u> cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Buffalo Mills, Pa.</u>	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Benedict Skitaralis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Harvey H. Leigler</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 21, 1930</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lybarger Cemetery</u>	22d. LOCATION (City, town, or county) <u>Buffalo Mills, Pa.</u>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Leigler</u>		ADDRESS <u>Hyndman, Pa.</u>		24a. REC'D BY REGISTRAR MAR 23 1930 DATE	24b. REGISTRAR'S SIGNATURE <u>Wm. S. Kline</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2739 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02751

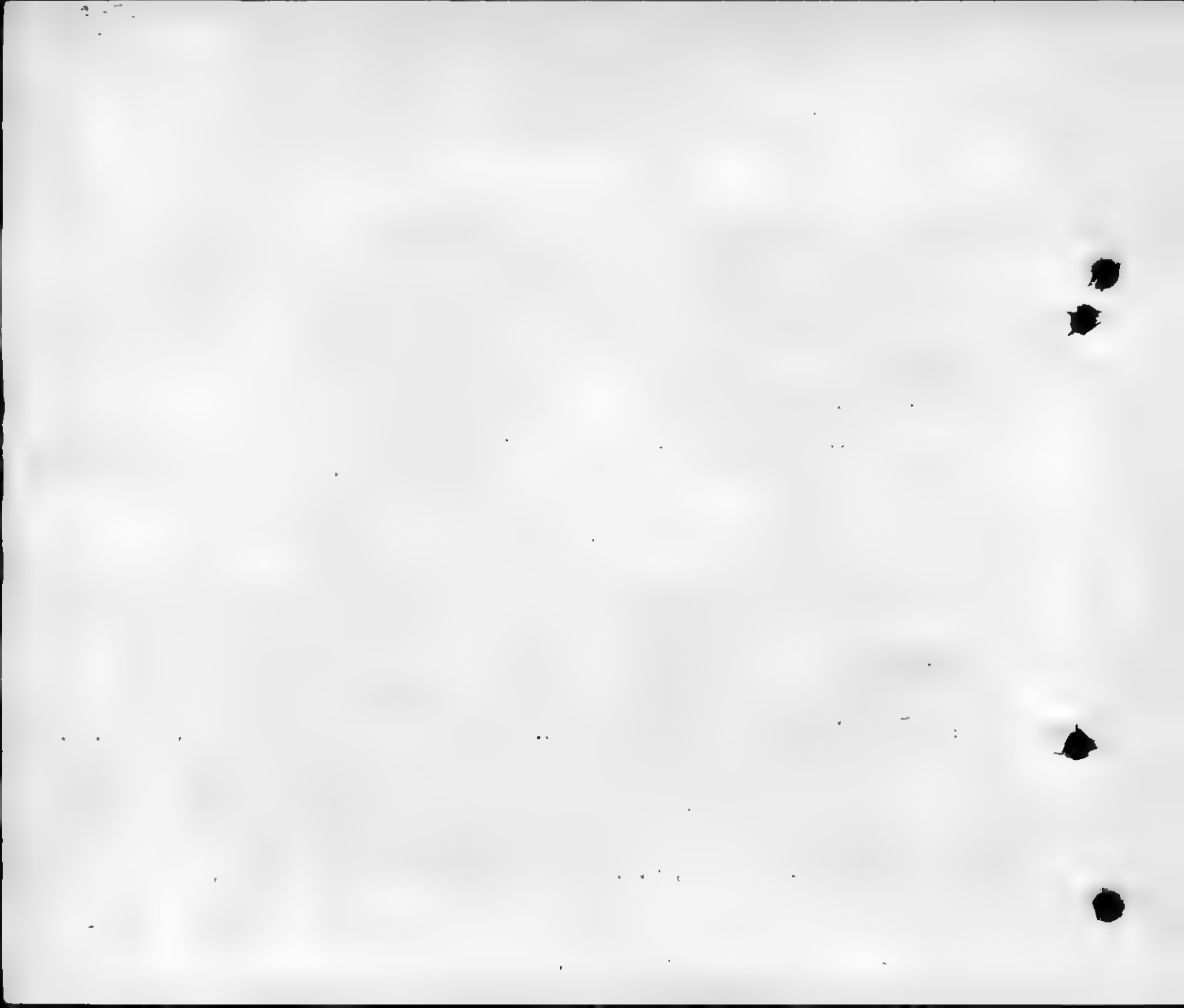
FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cute</u>		c. LENGTH OF STAY IN 1b -----		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Luke's Hospital, Cumberland</u>				d. STREET ADDRESS <u>433 Lehigh St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>EUGENE</u> Last <u>LUSHBAUGH</u>				4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 3 1931</u>	
				9. AGE (In years last birthday) <u>28</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
						11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Charlton Bros</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Howard L. Lushbaugh Sr</u>				14. MOTHER'S MAIDEN NAME <u>Mary Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-24-3367</u>		17. INFORMANT <u>Mrs. George J. Lushbaugh</u>			
				Address <u>47 Lehigh St Hagerstown Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Skull</u>							
DUE TO <u>truck accident</u>							
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.							
DUE TO <u> </u>							
DUE TO <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of truck thrown out and run over by rear wheels</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>11:00</u> <u>P.M.</u> <u>Mar. 8</u> <u>1960</u>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt. #40 23 miles east Cumberland, Alleg. Md.</u>	
				20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 8, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u> </u> <u> </u> <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew S. ...</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>MAR 11 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give flag 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, Baltimore, Maryland, for burial, cremation, or removal, and in any event within 72 hours after death.



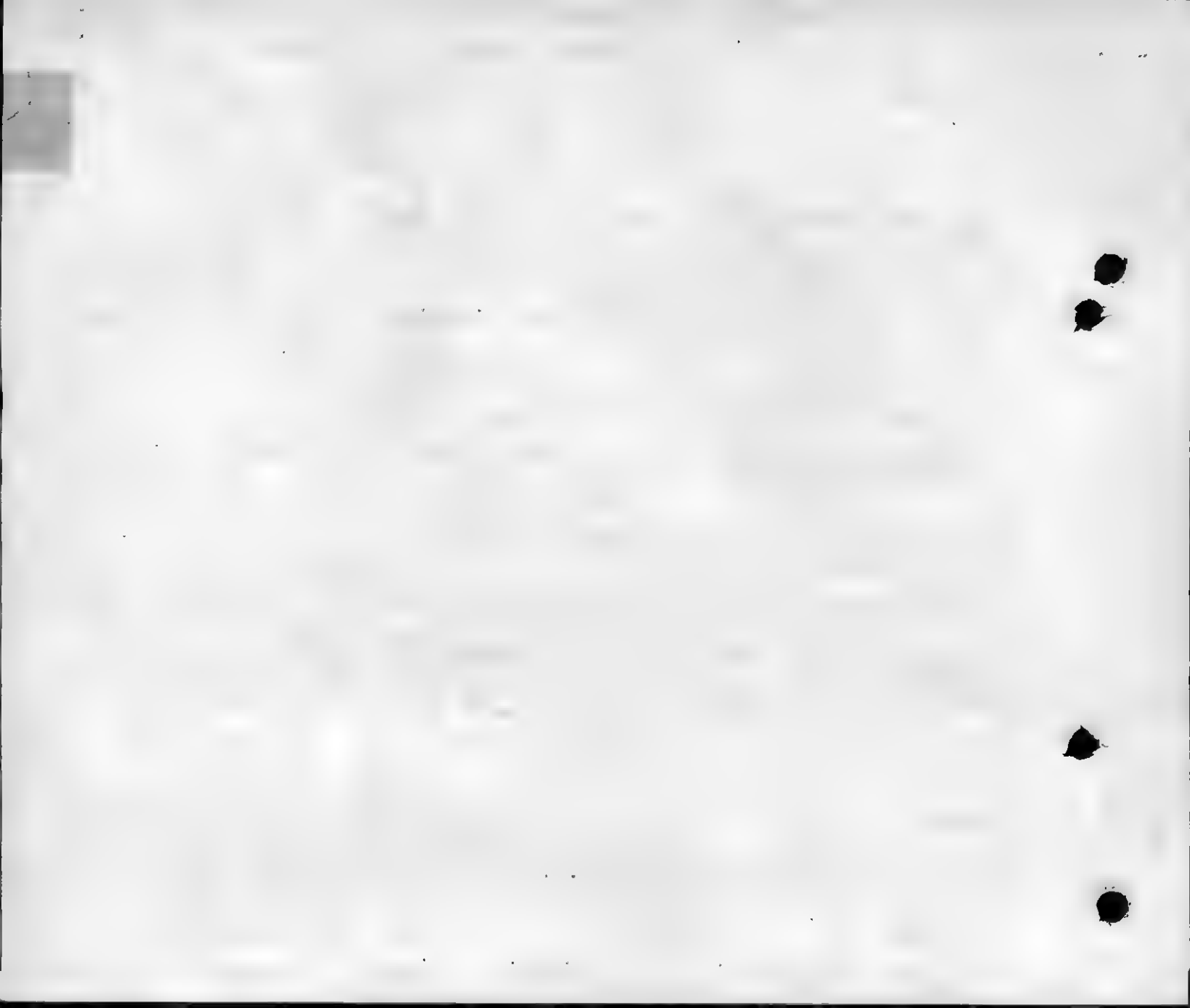
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2750 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 61 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital				d. STREET ADDRESS Potomac Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter Raymond Mahaney Middle Last				4. DATE OF DEATH Month March Day 19 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 29, 1898	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0		10. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Lab Assistant	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James Mahaney				14. MOTHER'S MAIDEN NAME Sarah Owens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs. Anna Mahaney, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 19, 1960				DATE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 22, 1960		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR MAR 22 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2751 CERTIFICATE OF DEATH

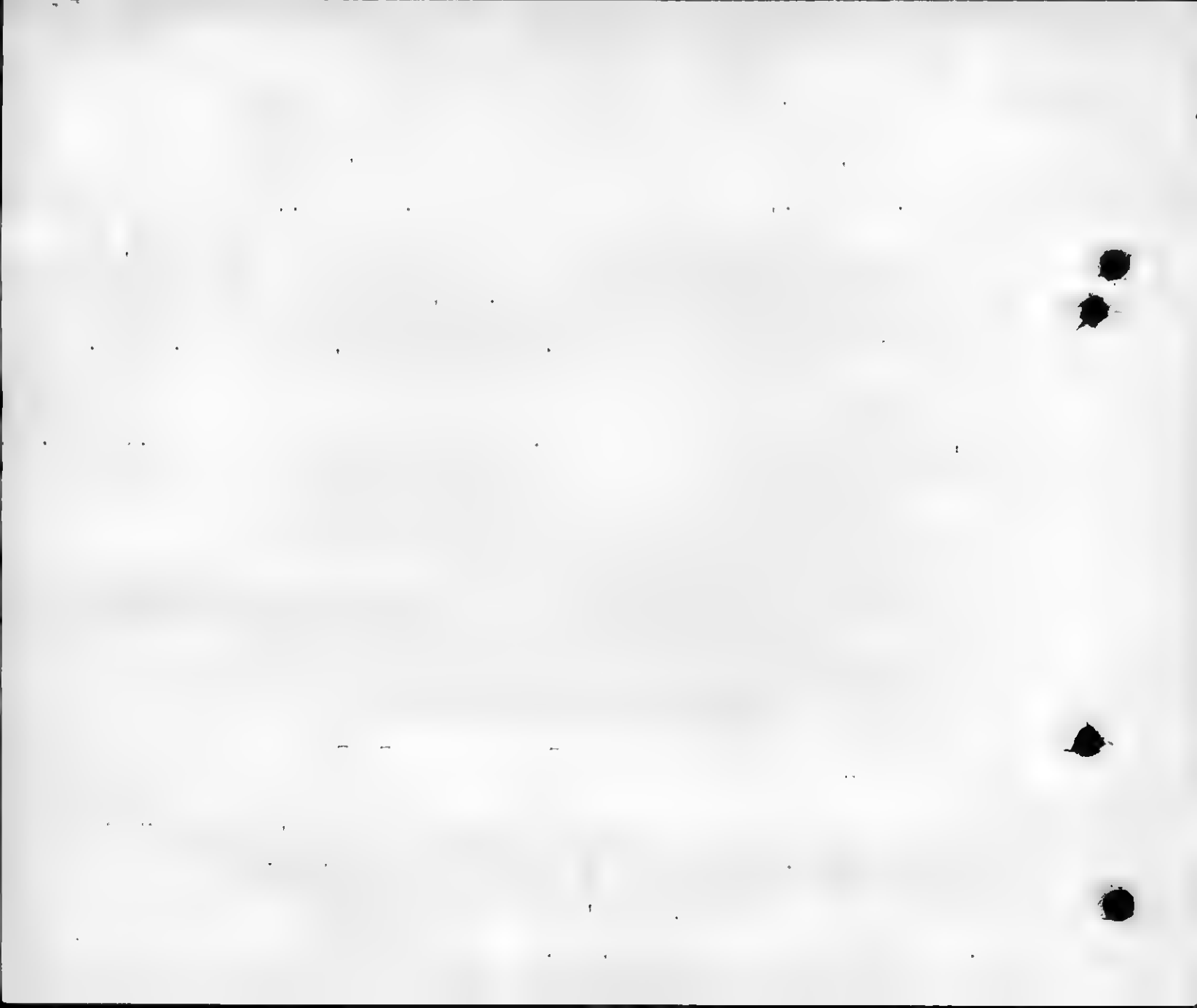
02753

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 So. Lee St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle MANK Last MANK		4. DATE OF DEATH Month March Day 20 Year 1960	
5. SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1899
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	
11. BIRTHPLACE (State or foreign country) Frank-on-Main, Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frantz Mank		14. MOTHER'S MAIDEN NAME Eleanor Vogel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16 SOCIAL SECURITY NO 214-07-6374	
17. INFORMANT Mrs. Beulah Mank		Address 209 So. Lee St., Cumb.Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 12 mos
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town)		(County) (State)	
21. I certify that I attended the deceased from 9-26-59 , 19____, to 3-20-60 , 19____, that I last saw the deceased alive on 3-20-60 , 19____, and that death occurred at 6:05 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph W. Ballin		ADDRESS (Street, city or town, state) 62 Greene St.,	
PHYSICIAN'S NAME (Type) Ralph W. Ballin M.D.		DATE SIGNED 3-21-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-60	
22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23 FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR MAR 24 '60		24b. REGISTRAR'S SIGNATURE William S. K...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 3. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



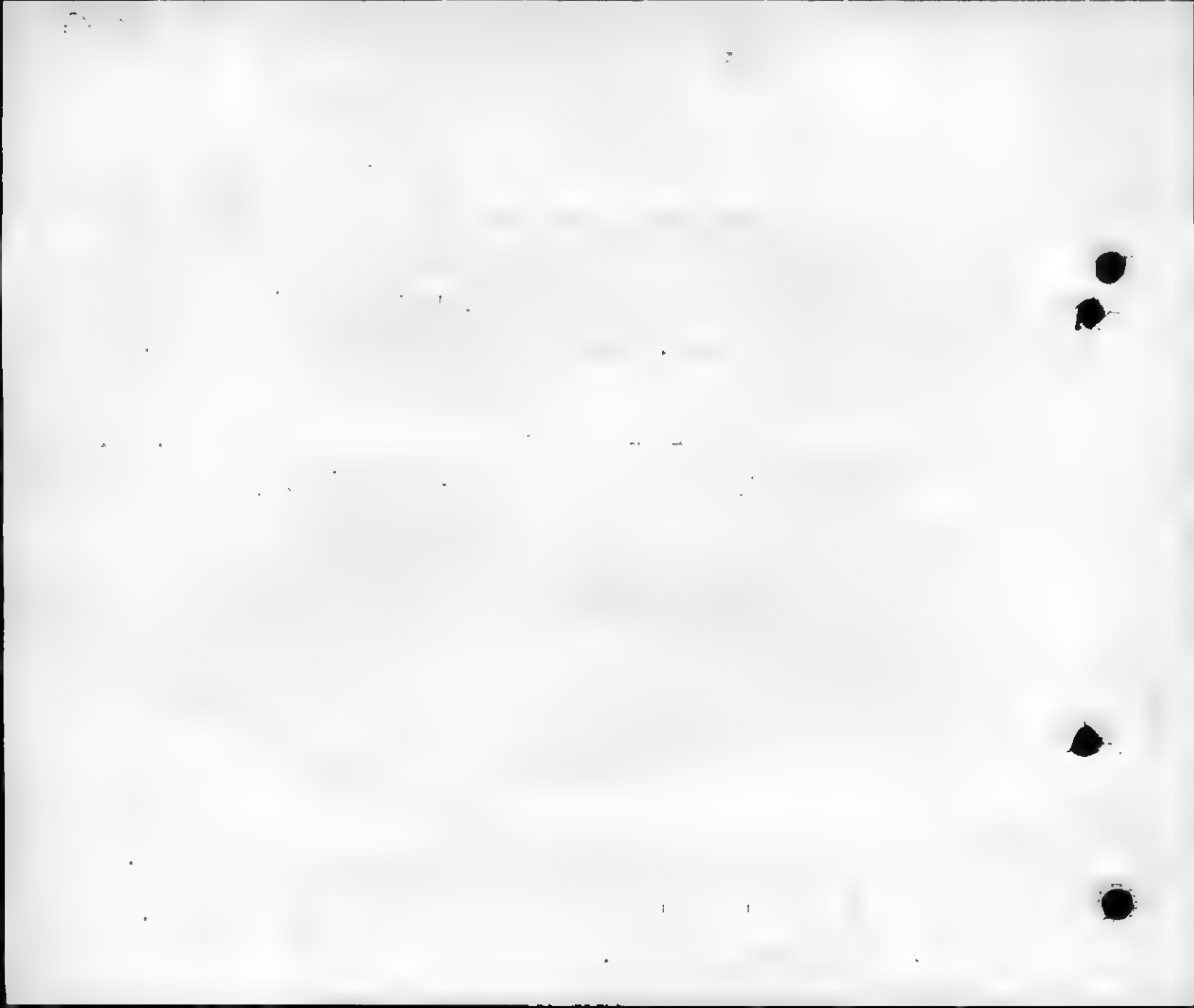
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2782 CERTIFICATE OF DEATH

02754

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM MASON		4. DATE OF DEATH MARCH 3, 1960	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 8, 1875
9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MAINTENANCE		10b. KIND OF BUSINESS OR INDUSTRY Dept. store	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MAN UNKNOWN		14. MOTHER'S MAIDEN NAME MARTHA FIDDLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 216-09-8568	
17. INFORMANT MRS. LULA CHAPMAN, KEYSER, W. VA.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 29, 1960 to Mar 3, 1960 , that (I) (we) last saw the deceased alive on Mar 3, 1960 and that death occurred at 6:30 p.m. from the causes and on the date stated above.			
22a. SIGNATURE W O McLane		22b. DATE SIGNED 3-4-60	
22c. PHYSICIAN'S NAME (Type) W. O. McLANE, M. D.		22d. ADDRESS E. MAIN ST., FROSTBURG, MD.	
23a. B.J.R.A., CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 6 '60	
23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. DURST, FROSTBURG, MD.		25a. REC'D BY REGISTRAR MAR 8 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the State Board of Health will remove carbon copy 1 and 2 should be filled with the name of the deceased, the date of death, and in any event, within 72 hours after death.



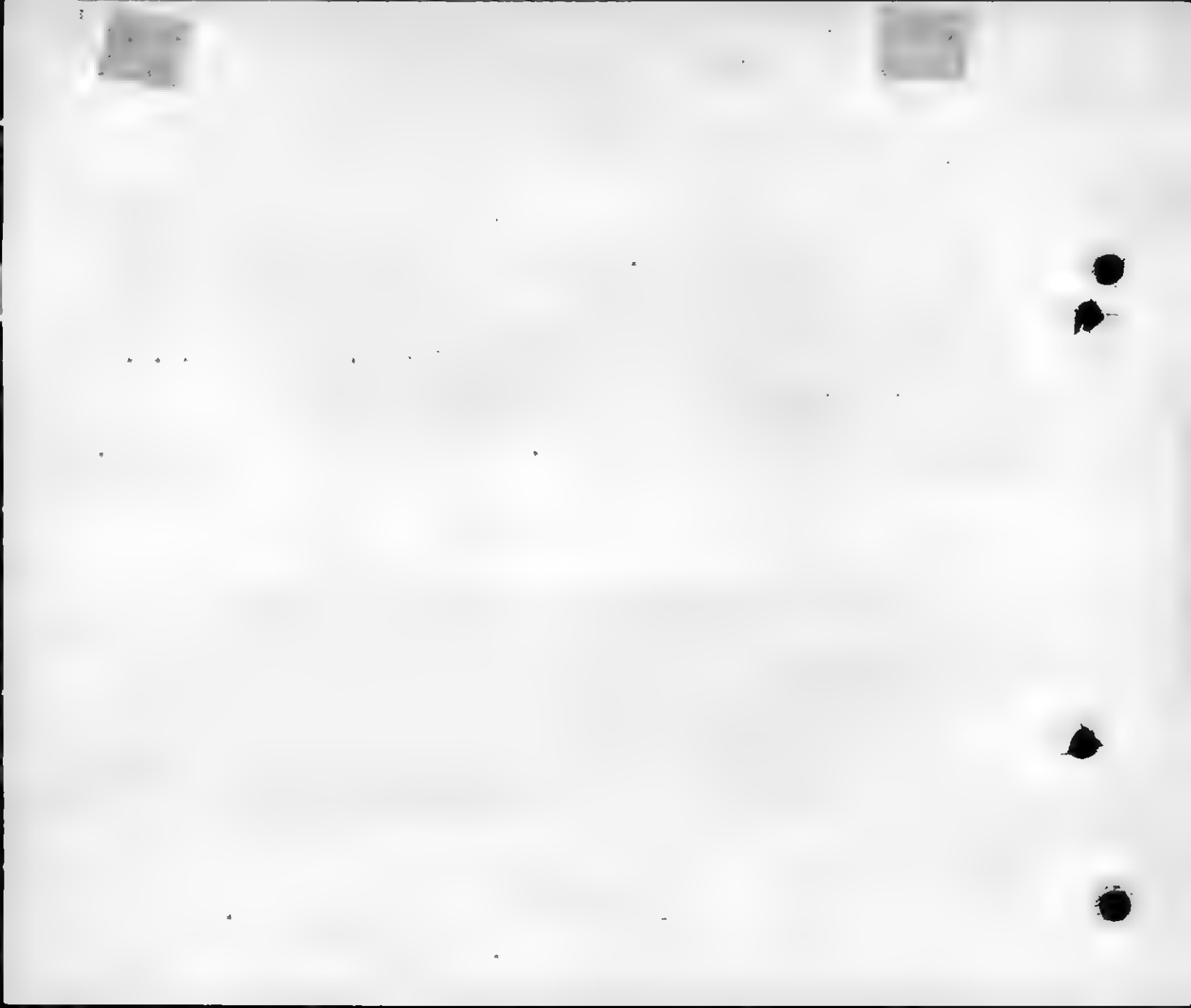
2786 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b X Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Island Street		d. STREET ADDRESS Island Street	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle E. Last McUTCHEON		4. DATE OF DEATH Month 3 Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/1887
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own Home		10b. KIND OF BUSINESS OR INDUSTRY Moscow, MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Timmey		14. MOTHER'S MAIDEN NAME Sarah Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. John McCutcheon		Address Moscow, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 mos.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 19 57 to March 19 , 19 60 that I last saw the deceased alive on March 15 , 19 60 , and that death occurred at 6:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Main St. DATE SIGNED 3.19.60 ACTUAL SIGNATURE Leslie R. Miles Jr. M.D. Leslie R. Miles Jr., M.D. Lonaconing Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/22/1960	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town, or county) (State) Moscow, MD.
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		ADDRESS LONA CONING? MD.	24a. REC'D BY REGISTRAR MAR 22 '60
		24b. REGISTRAR'S SIGNATURE Carling S. Hunt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be notified. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02756

2752

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 17 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				/d. STREET ADDRESS 491 BALTIMORE AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle Edward Last McKalevey				4. DATE OF DEATH Month MARCH Day 21 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH MAY 5, 1909	
9. AGE (In years last birthday) 50		10. IF UNDER 1 YEAR Months 5 Days 12 Hours 00 Min 00		11. IF UNDER 24 HRS Hours 00 Min 00		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Co-Owner & Mgr.				10b. KIND OF BUSINESS OR INDUSTRY Southern Bar		11. BIRTHPLACE (State or foreign country) Williamsport, Md.	
13. FATHER'S NAME James McKalevey				14. MOTHER'S MAIDEN NAME Anna Shields			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,				16. SOCIAL SECURITY NO. 214-07-4885		INFORMANT Mrs. Thomas Beck Address 546 Nat. Hwy. La Vale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Thrombosis 592X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. (b) Chronic Glomerulonephritis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 12 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Bronchopneumonia						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 13 , 19 60 , to March 21 , 19 60 that I last saw the deceased alive on March 21 , 19 60 , and that death occurred at 10:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 126 N. Stallwood Street, Cumberland, Maryland DATE SIGNED 3/23/60							
ACTUAL SIGNATURE L. Michael Glick				PHYSICIAN'S NAME (Type) L. Michael Glick, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/24/60		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE MAR 28 '60		24b. REGISTRAR'S SIGNATURE Charles E. House	

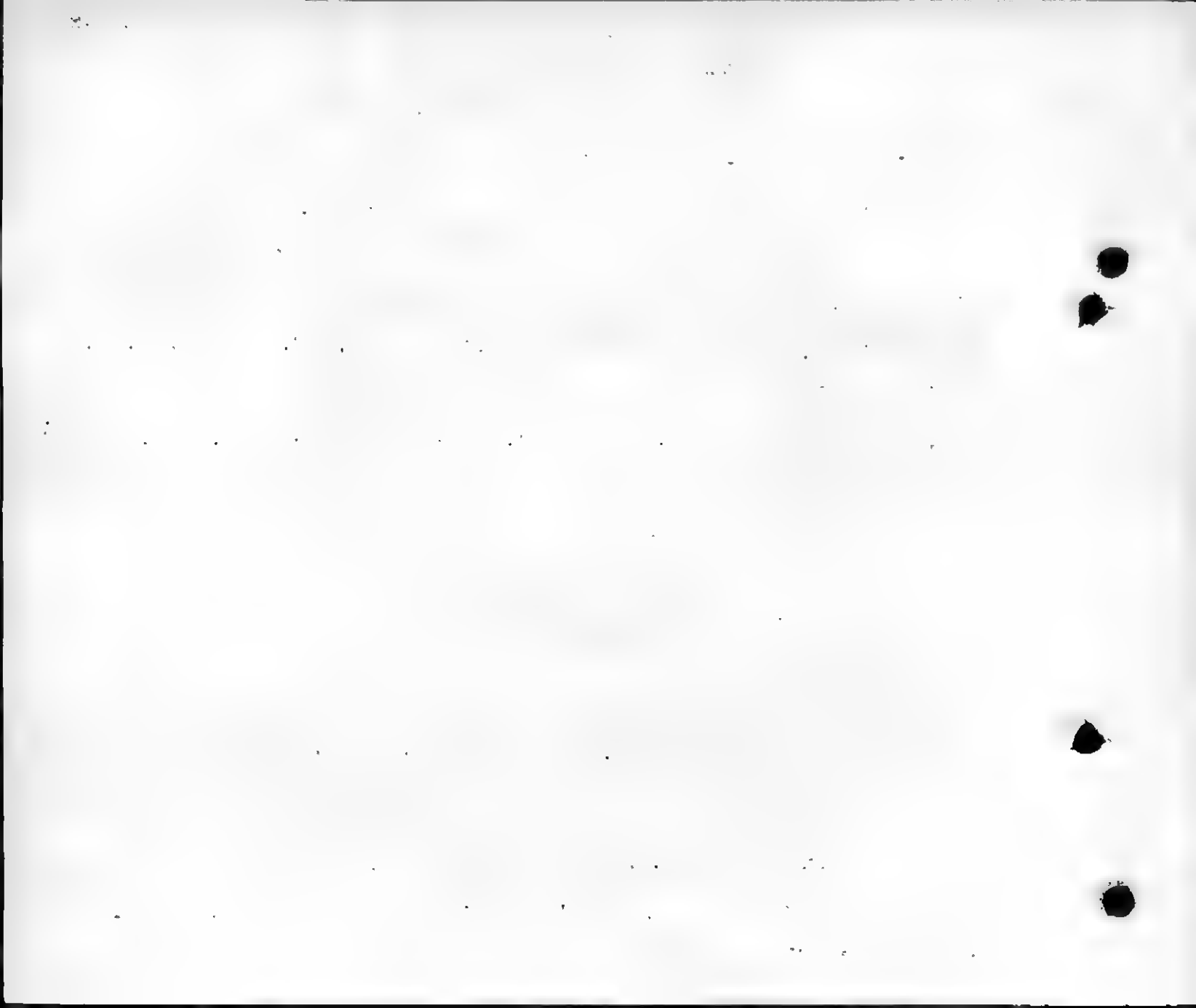
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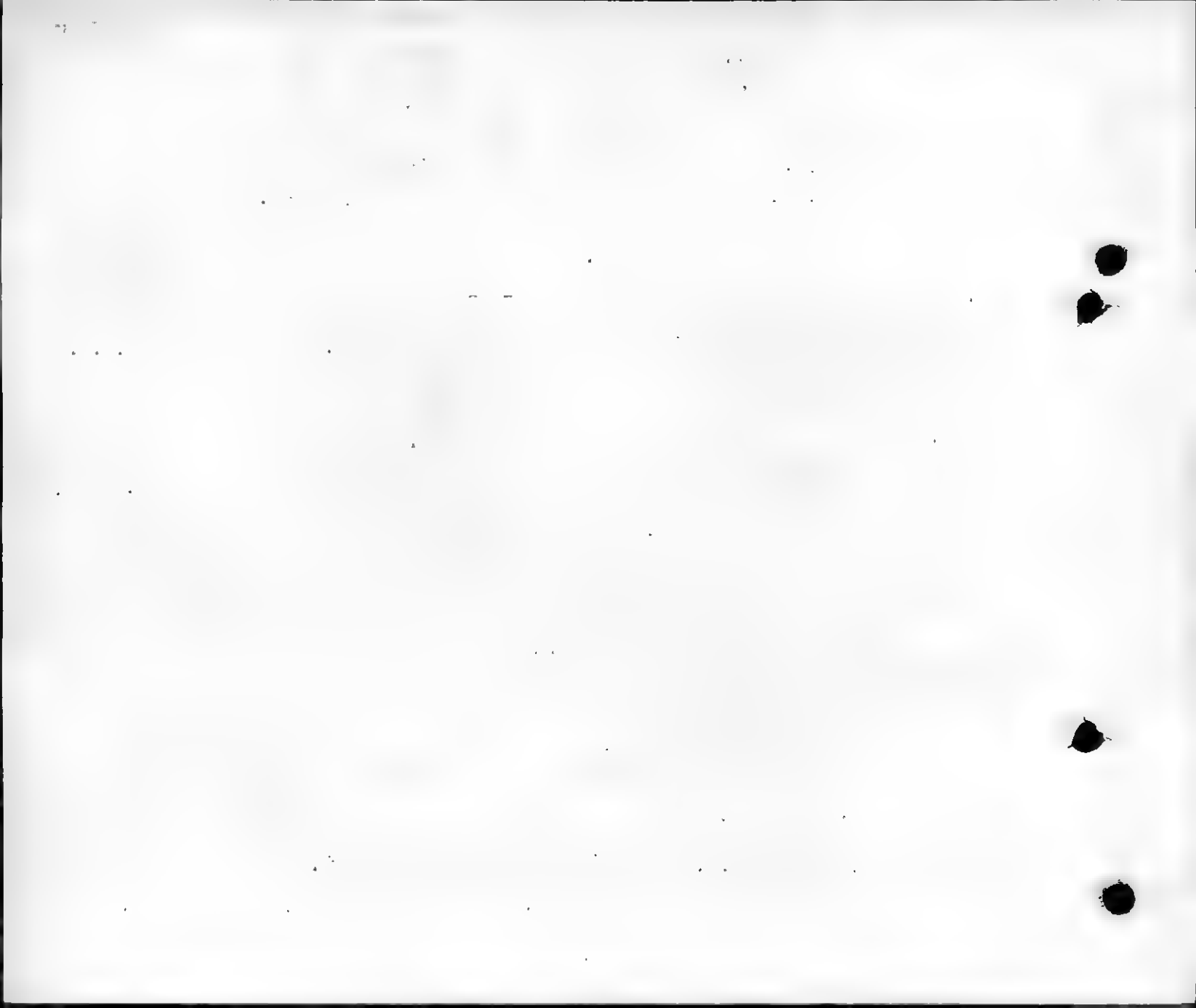
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
		f. STREET ADDRESS 1302 OLDTOWN RD.	
3. NAME OF DECEASED (Type or print) First JANES Middle H. Last MERRILL		4. DATE OF DEATH Month 3 Day 10 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-11-78
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 02 Days 02 Hours 02 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mech. Operator Rubber Tire		10b. KIND OF BUSINESS OR INDUSTRY Plant	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? Merrill Md. U.S.A.	
13. FATHER'S NAME Elias Merrill		14. MOTHER'S MAIDEN NAME Barbara Broadwater	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT PT'S CHART.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 420.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 months 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 3-7- 19 60 to 3-10- 19 60 , that I last saw the deceased alive on 3-10- 19 60 , and that death occurred at 8:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE L. Brings M.D. _____ PHYSICIAN'S NAME (Type) L. BRINGS, M.D. 57 GREENE ST.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-13-60	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24a. REC'D BY REGISTRAR MAR 15 '60	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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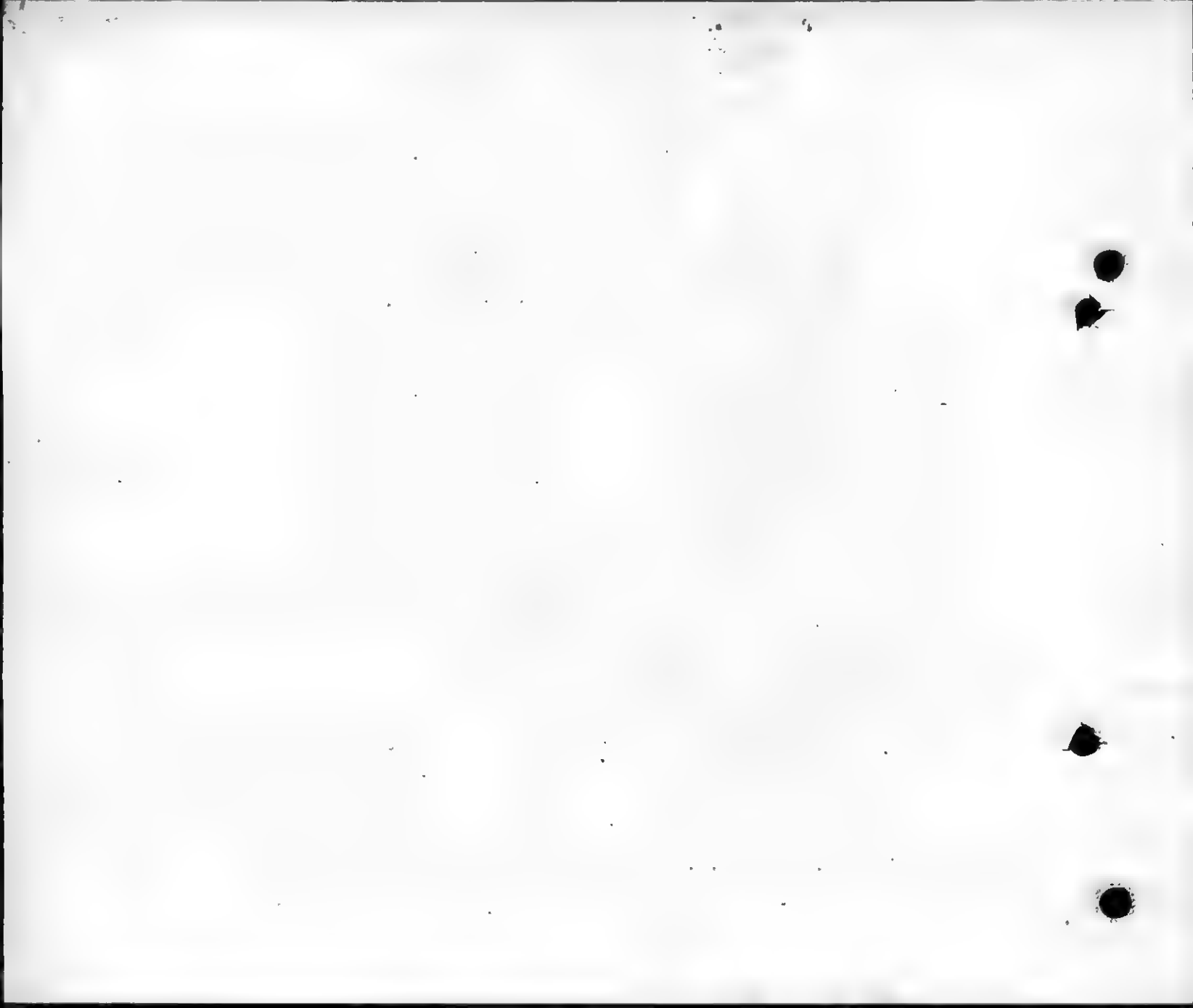
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
f. STREET ADDRESS 632 FAIRMONT AVE,		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle MERRITT Last MERRITT		4. DATE OF DEATH Month MARCH Day 10 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH JULY 14, 1921
9. AGE (In years lost birthday) 38 yrs		10. IF UNDER 1 YEAR Months 3 Days 10 Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY House	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM MITCHELL		14. MOTHER'S MAIDEN NAME EVELYN LUTEMAN (DECEASED)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sacred Heart Hospital Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 31X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lupus erythematosus INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19 59 to March 9, 19 60 that I lost saw the deceased alive on March 9, 19 60 and that death occurred at 2:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED March 14 '60			
ACTUAL SIGNATURE David T. Rees M.D.			
PHYSICIAN'S NAME (Type) DAVID T. REES, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 12 1960	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		24a. REC'D BY REGISTRAR Mar 14 '60	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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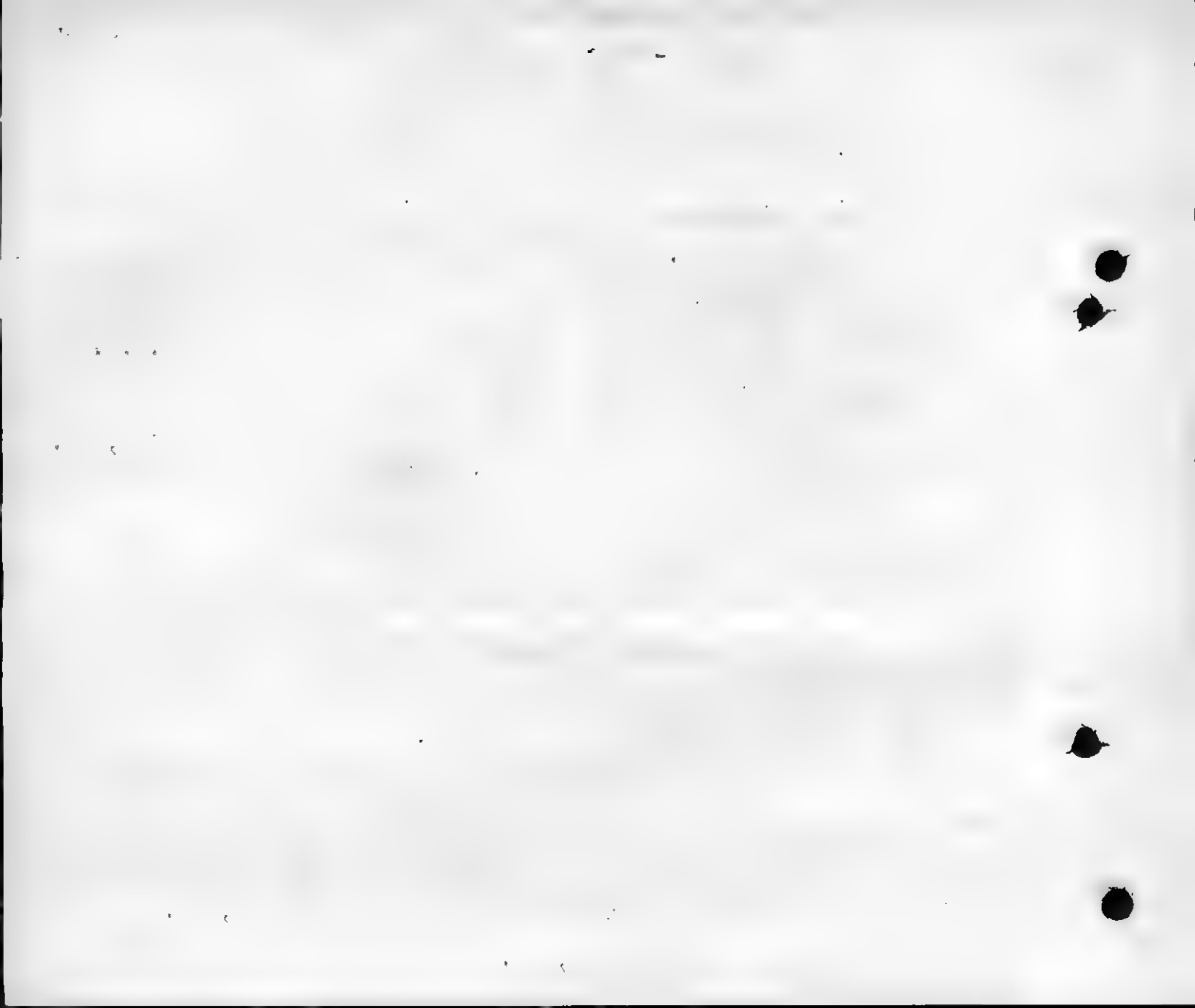
-CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN It X Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main Street		d. STREET ADDRESS Main Street	
3. NAME OF DECEASED (Type or print) MARGARET H. MOORE		4. DATE OF DEATH Month 3 Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/2/1878
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Smith		14. MOTHER'S MAIDEN NAME Margaret Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Miss Hilda Moore		Address Lonaconing, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 4-2-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic CV disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 hours years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1956 , to March 19, 1960 , that I last saw the deceased alive on Feb 1960 , and that death occurred at 1:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leslie R. Miles, Jr.		ADDRESS (Street, city or town, state) Main St. Lonaconing Md.	
PHYSICIAN'S NAME (Type) LESLIE R. MILES, JR. M.D.		DATE SIGNED 3-19-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/22/1960	22c. NAME OF CEMETERY OR CREMATORY Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, MD.
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		ADDRESS LONA CONING, MD.	
24a. REC'D BY REGISTRAR MAR 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers from the back of the certificate and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2800

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 60 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 3,				d. STREET ADDRESS Route 3,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle L. Last MOWER				4. DATE OF DEATH Month March Day 5, Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1884		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edgar Mower				14. MOTHER'S MAIDEN NAME Amanda ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214 07 1197A		17. INFORMANT Address Mrs. Ida Mower, Route 3, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis, Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH Weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		March 5, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 8, 1960		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE MAR 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

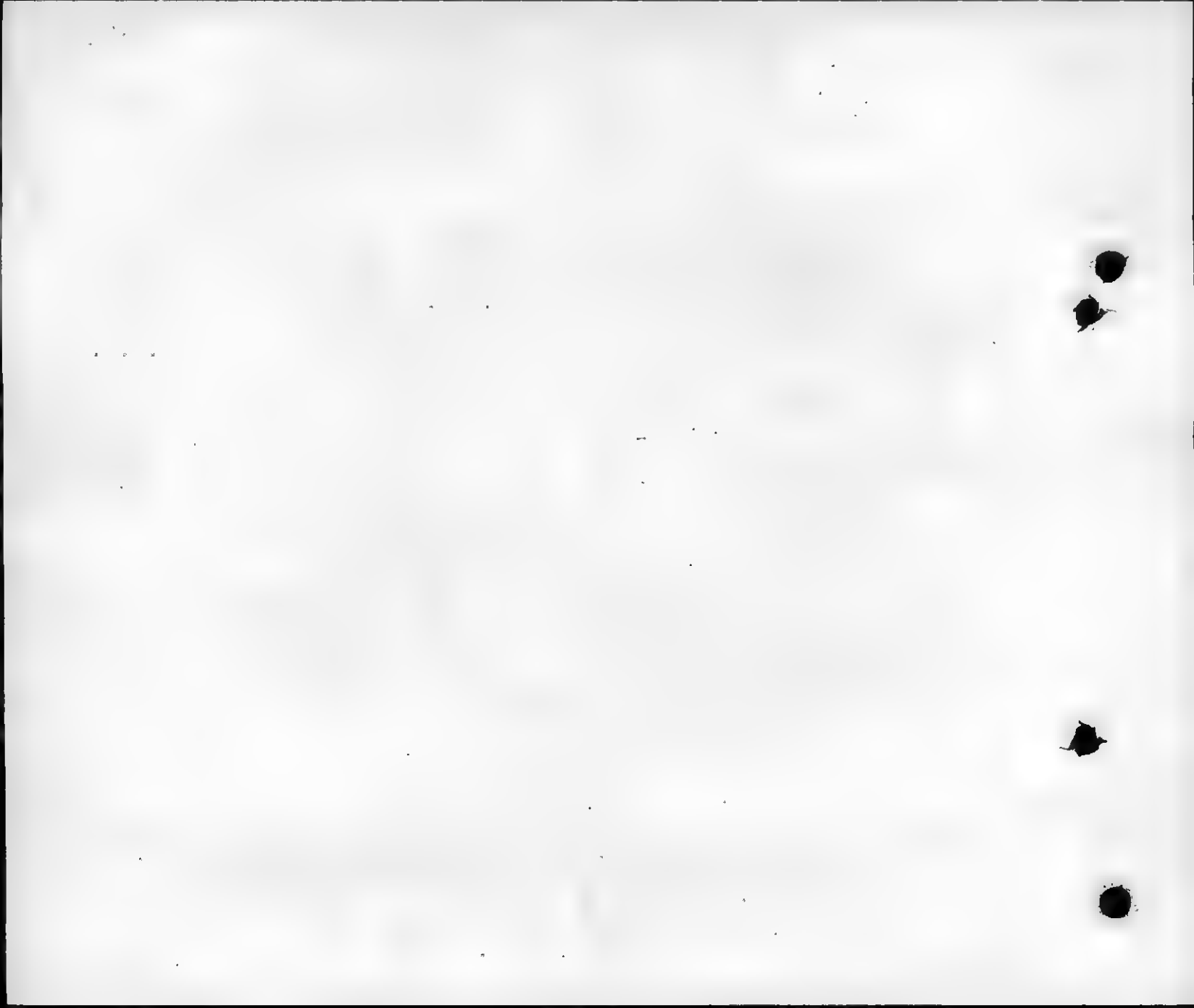


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02761

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE PENNSYLVANIA b. COUNTY ALLEGHENY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 7 WKS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		e. STREET ADDRESS PITTSBURGH 75X-3	
3 NAME OF DECEASED (Type or print) CHARLES First CLAYTON Middle MURPHY Last		4. DATE OF DEATH MARCH Month 15 , Day 1960 Year	
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH JAN. 29, 1900
9 AGE (In years last birthday) 60 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of workng life, even if retired) MACHINE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY COPPER MILL	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR MURPHY		14. MOTHER'S MAIDEN NAME CORLISTA GROGHAN	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 169-10-4191	
17. INFORMANT SAMUEL MURPHY, La VALE, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma of Liver (c) Carcinoma of Acending Colon.			INTERVAL BETWEEN ONSET AND DEATH 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January 5, 1960 to March 15, 1960 , that (I) (we) last saw the deceased alive on March 15, 60 and that death occurred at 7 AM , from the causes and on the date stated above.			
22a. SIGNATURE Alvin J. Walters M.D.		22b. DATE SIGNED 3/16/60	
22c. PHYSICIAN'S NAME (Type) ALVIN J. WALTERS, M. D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAR. 17 '60	23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY	23d. LOCATION (City, town, or county) (State) GARRETT COUNTY
24. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst		25a. REC'D BY REGISTRAR FROSTBURG, MD. DATE MAR 18 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Knecht	

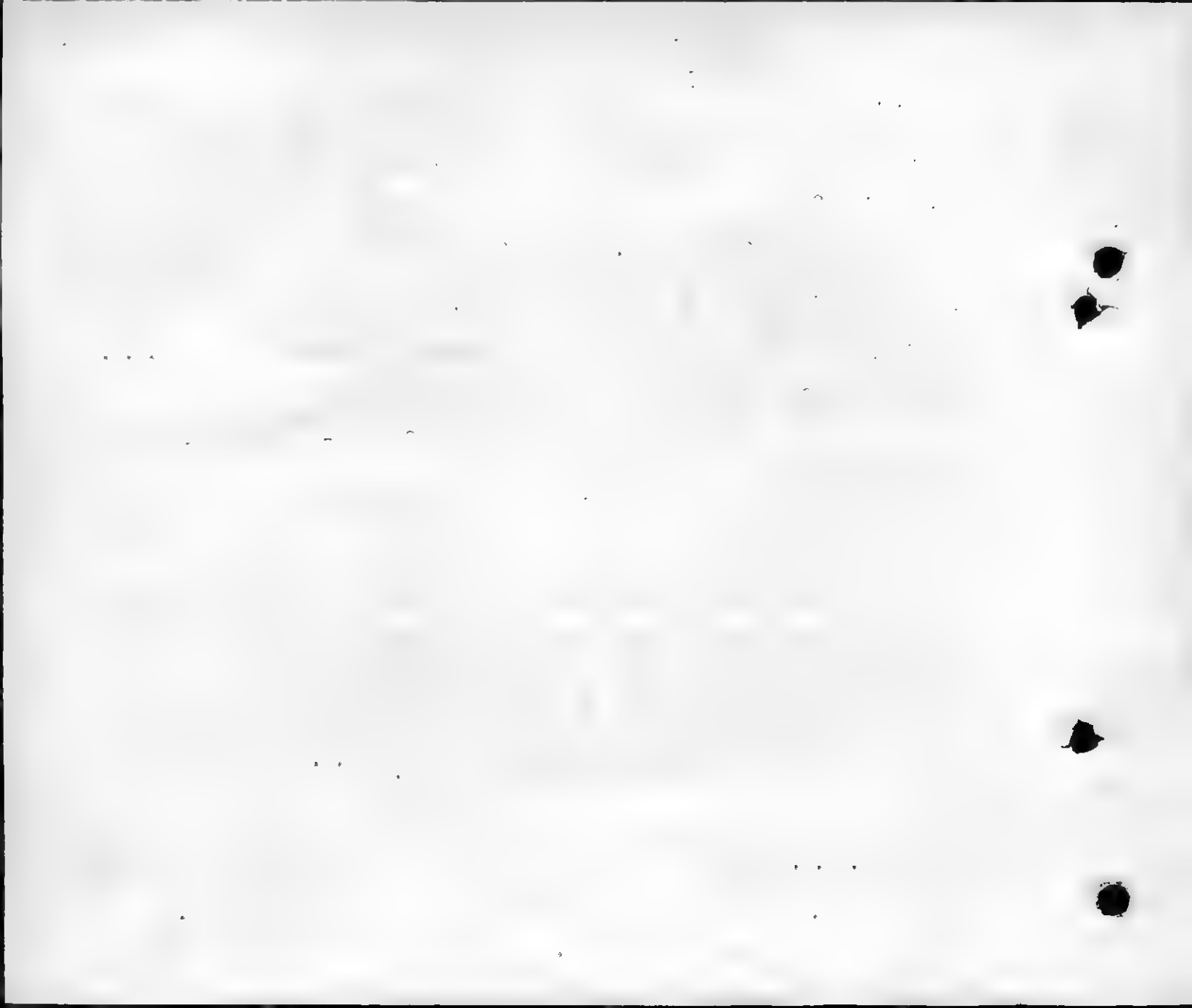
may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from page 1 and 2 should be filed with the State Board of Health for burial, cremation, or removal, and in any event, within 72 hours after death.



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 2755 CERTIFICATE OF DEATH

02762

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 23 DAYS		d. STREET ADDRESS 523 VALLEY STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle E. Last MYERS		4. DATE OF DEATH Month MARCH Day 3 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 23, 1873
9. AGE (In years lost birthday) yrs. 86		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Celanese	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN MYERS		14. MOTHER'S MAIDEN NAME CATHERINE GREEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 220 10 8940	
17. INFORMANT WARWICK & MEMORIAL AVENUE		18. MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Impairment of age. DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Episodes of bleeding from a marginal ulcer.			INTERVAL BETWEEN ONSET AND DEATH Since April 1946
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-1-1960 to 4-3-1960 and that death occurred at 12:30 P.M. from the causes and on the date stated above			
22a. SIGNATURE W.F. Williams M.D.		22b. ADDRESS Cumberland, Md.	
22c. PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS		22d. ADDRESS Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 5, 1960	
23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		25. REC'D BY REGISTRAR MAR 7 '60	
25a. REGISTRAR'S SIGNATURE Arthur L. Hines			



2756

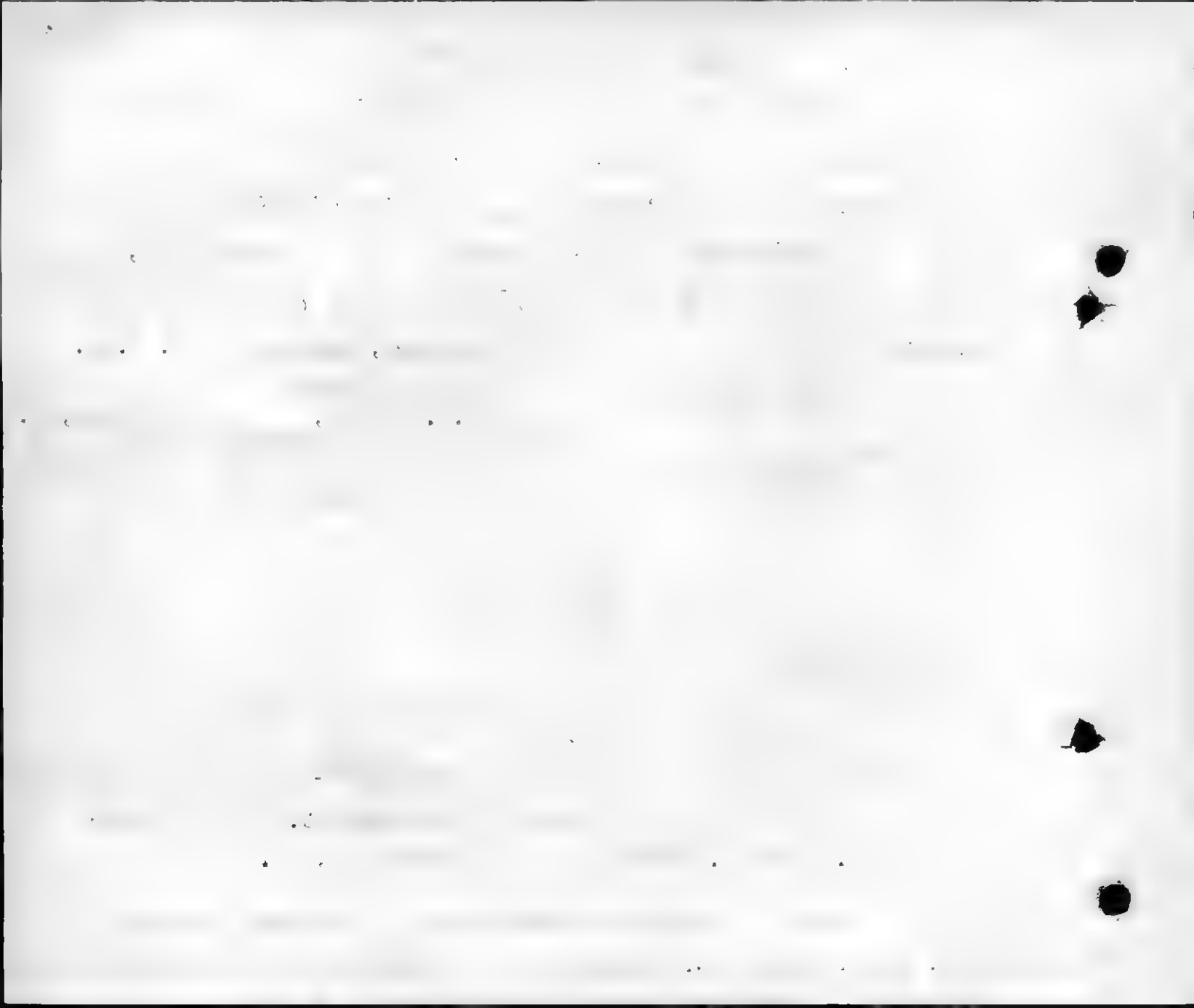
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2/20/60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
f. STREET ADDRESS 222 Pear Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Ellen Last Odgers		4. DATE OF DEATH Month March Day 1 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/1884
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Frostburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alfred Thomas		14. MOTHER'S MAIDEN NAME Rebecca Hayes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
INFORMANT P.O. Box 599, Address Cumberland, Md.		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Chronic Myocardial Degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) Cerebral arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ulceration Rt. Lower Leg.			INTERVAL BETWEEN ONSET AND DEATH ? ? ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/20/60 , 19 to 3/1/60 , 19, that I last saw the deceased alive on 3/1/60 , 19, and that death occurred at 12:00 Noon , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 3/1/60			
ACTUAL SIGNATURE James E. McLean M.D.		PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.	
22a. BURIAL, CREMAT. OR REMOVAL (Specify) Burial	22b. DATE THEREOF 3/4/60	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR MAR 10 '60	24b. REGISTRAR'S SIGNATURE Carl E. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remain in carbon paper, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 1

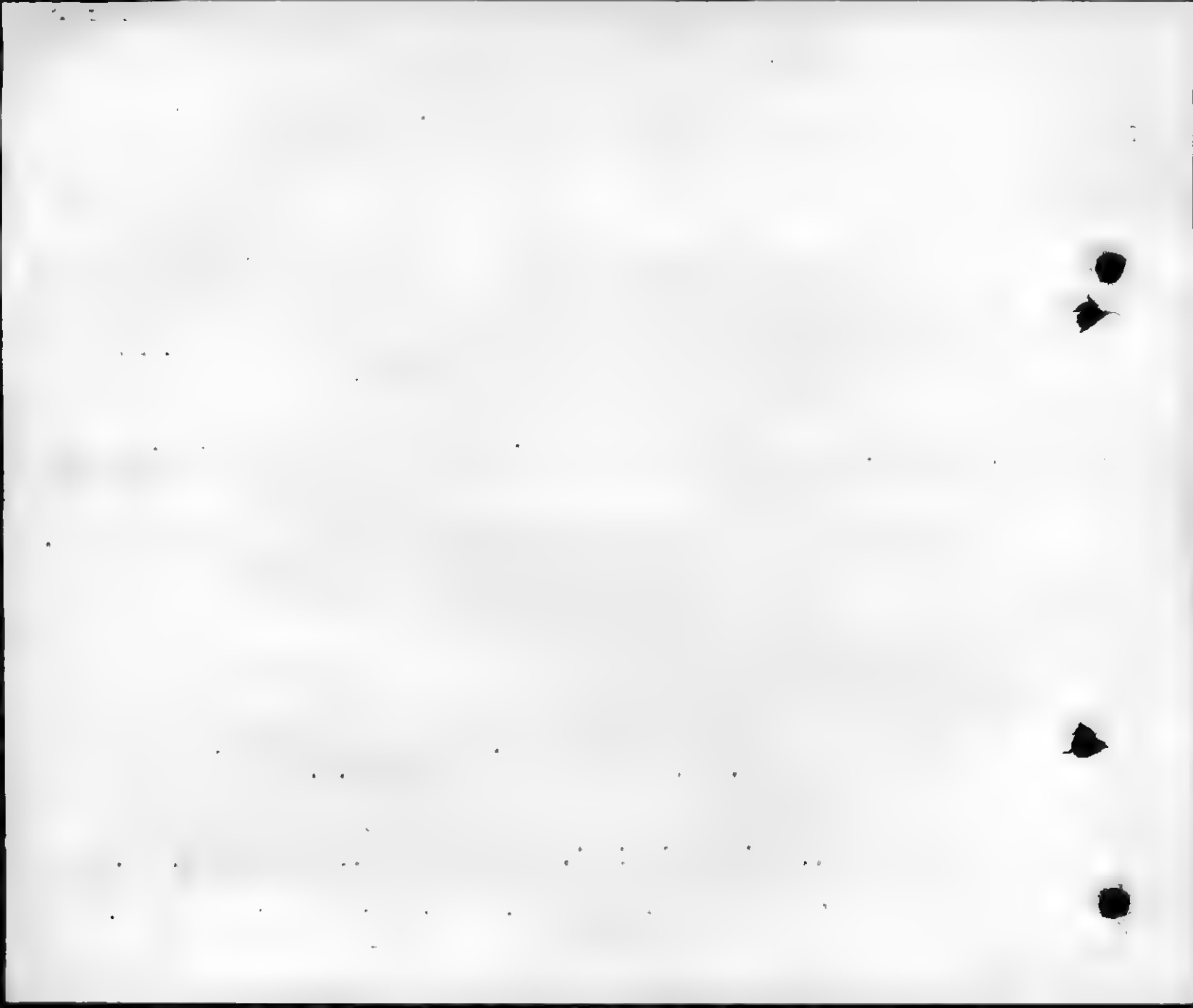
may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the General Director should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health.

2790

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02764

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>			c. LENGTH OF STAY IN 1b <u>54 Yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>42 Westernport</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>330 Front</u>				1d. STREET ADDRESS <u>330 Front</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Stanislaus Paskun</u>				4. DATE OF DEATH Month Day Year <u>Mar. 17 1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 7, 1868</u>		9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pan Room Operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clement Paskun</u>				14. MOTHER'S MAIDEN NAME <u>Rosalie Mainis</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>217-05-0984</u>		17. INFORMANT Address <u>Mrs. Monroe Pearce-Westernport, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>33. X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular accident</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): <u>Congestive heart failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. _____ 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1, 1960</u> to <u>March 17, 1960</u> , that (I) (we) last saw the deceased alive on <u>Mar. 17, 1960</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.								
22a. SIGNATURE <u>William W. Lesh</u> M.D.				22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>William W. Lesh, M.D.</u>				22d. ADDRESS <u>84 Main St., Westernport, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/21/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Bral</u>				ADDRESS <u>Westernport, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 22 '60</u>		
						25b. REGISTRAR'S SIGNATURE <u>Charles E. Hens</u>		



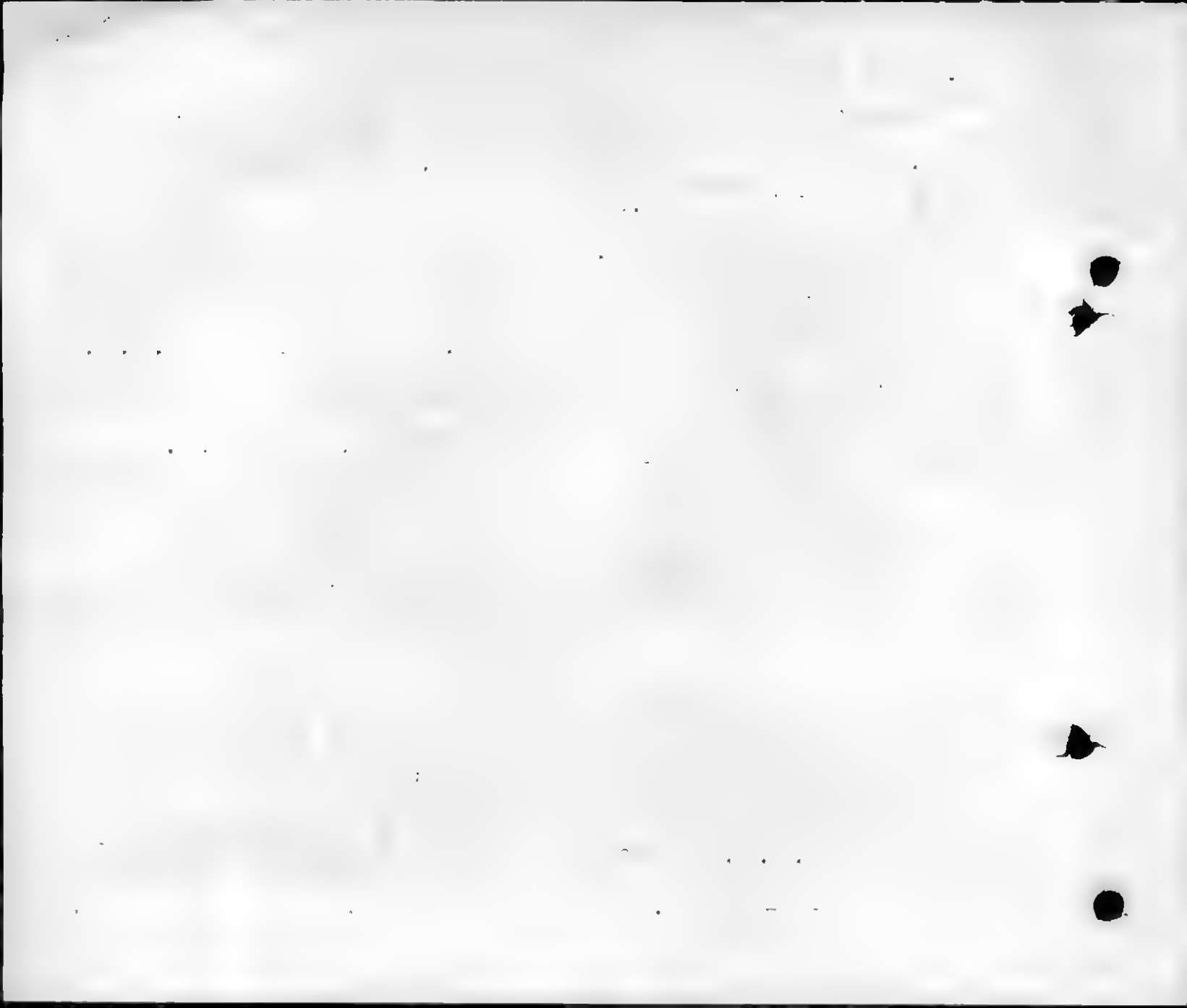
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02765

2788

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE			c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE, MARYLAND		
d. NAME OF HOSPITAL (If not in hospital, give name of place where death occurred) MEMORIAL HOSPITAL				d. STREET ADDRESS WARWICK & MEMORIAL AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last POLLOCK				4. DATE OF DEATH Month MARCH Day 8 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 20 1890		9. AGE (In years last birthday) 70 yrs	IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MT. SAVAGE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME WILLIAM HARDEN				14. MOTHER'S MAIDEN NAME LAURA SHAFFER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Chronic Hypertensive Cardiovascular Disease DUE TO (c) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH 5:10 PM 1956
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 5:10 19 59 to 3-8- 19 60 that (I) (we) last saw the deceased alive on 3-8- 19 60 and that death occurred 6:00 PM from the causes and on the date stated above.							
22a. SIGNATURE Wm. J. Williams				ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS				22d. ADDRESS Cumberland Md 3-9-60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-11-60		23c. NAME OF CEMETERY OR CREMATORY St. George's Cemetery		23d. LOCATION (City, town, or county) (State) Mt. Savage Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home				25a. REC'D BY REGISTRAR DATE MAR 11 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the General Director should be detached for use as the burial-transit permit. Then please remove carbon papers and forward to the State Board of Health for filing and to the State Board of Health for filing and to the State Board of Health for filing.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02766

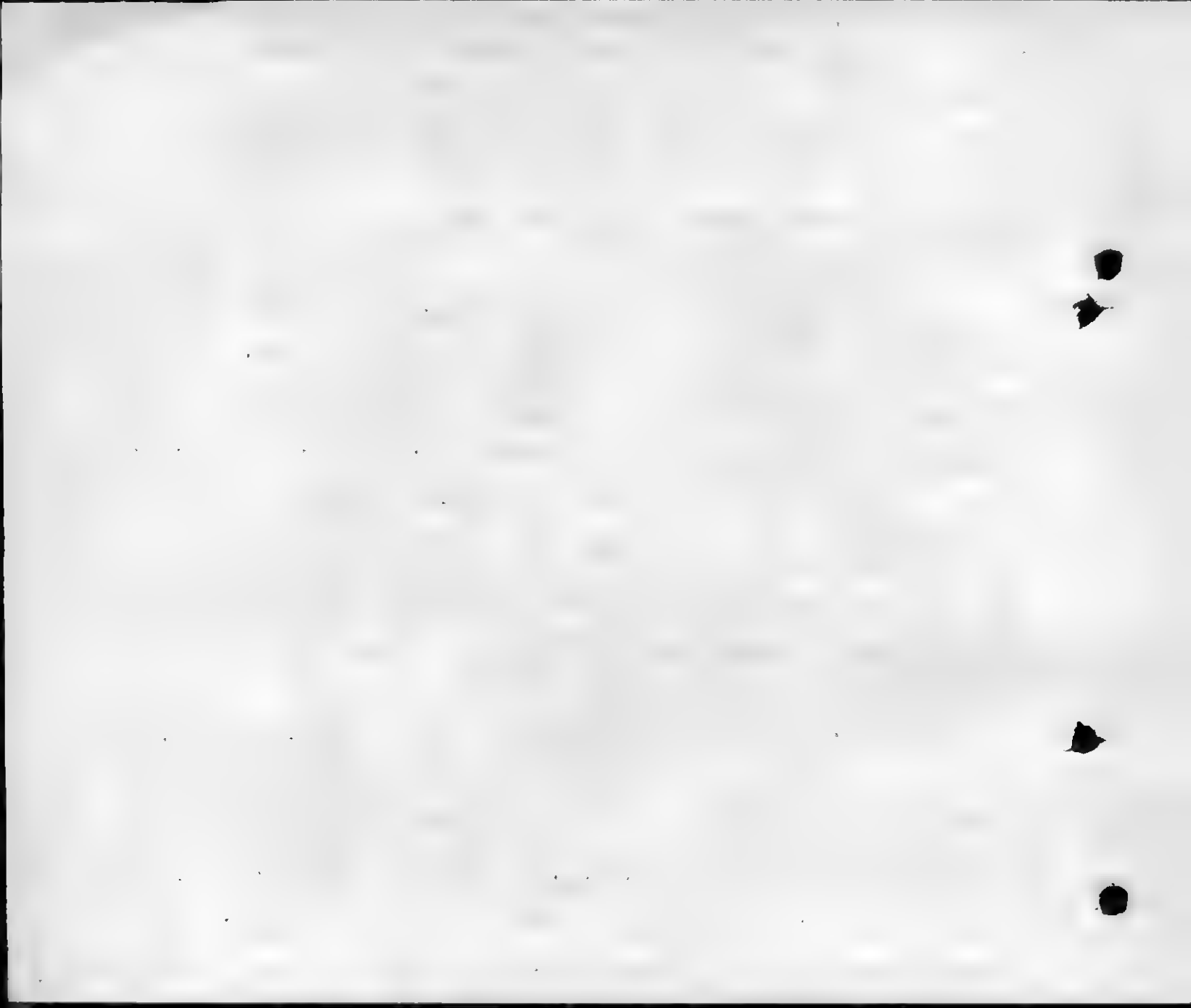
2757

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Bedford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN lb <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyndman</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>RD # 1</u>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>EUGENE</u> Last <u>PRINTY</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3, 1948</u>		9. AGE (In years last birthday) <u>12</u> yrs.	IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u>12</u> Min. <u>12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Allen Printy</u>				14. MOTHER'S MAIDEN NAME <u>Reada Burley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Robert A. Printy, Hyndman, Pa. RD#1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Contusions of Brain, Diffuse</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Skull Fractures</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit by automobile while on bicycle</u>					
20c. TIME OF INJURY Month, Day, Year <u>8:40 p.m. Mar. 9 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway near Hyndman, Bedford, Penna</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 12, 1960</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 13, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hyndman, Pa. ID#1</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert L. Kiefer</u>				ADDRESS <u>Hyndman, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 16 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kiefer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2758 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02767

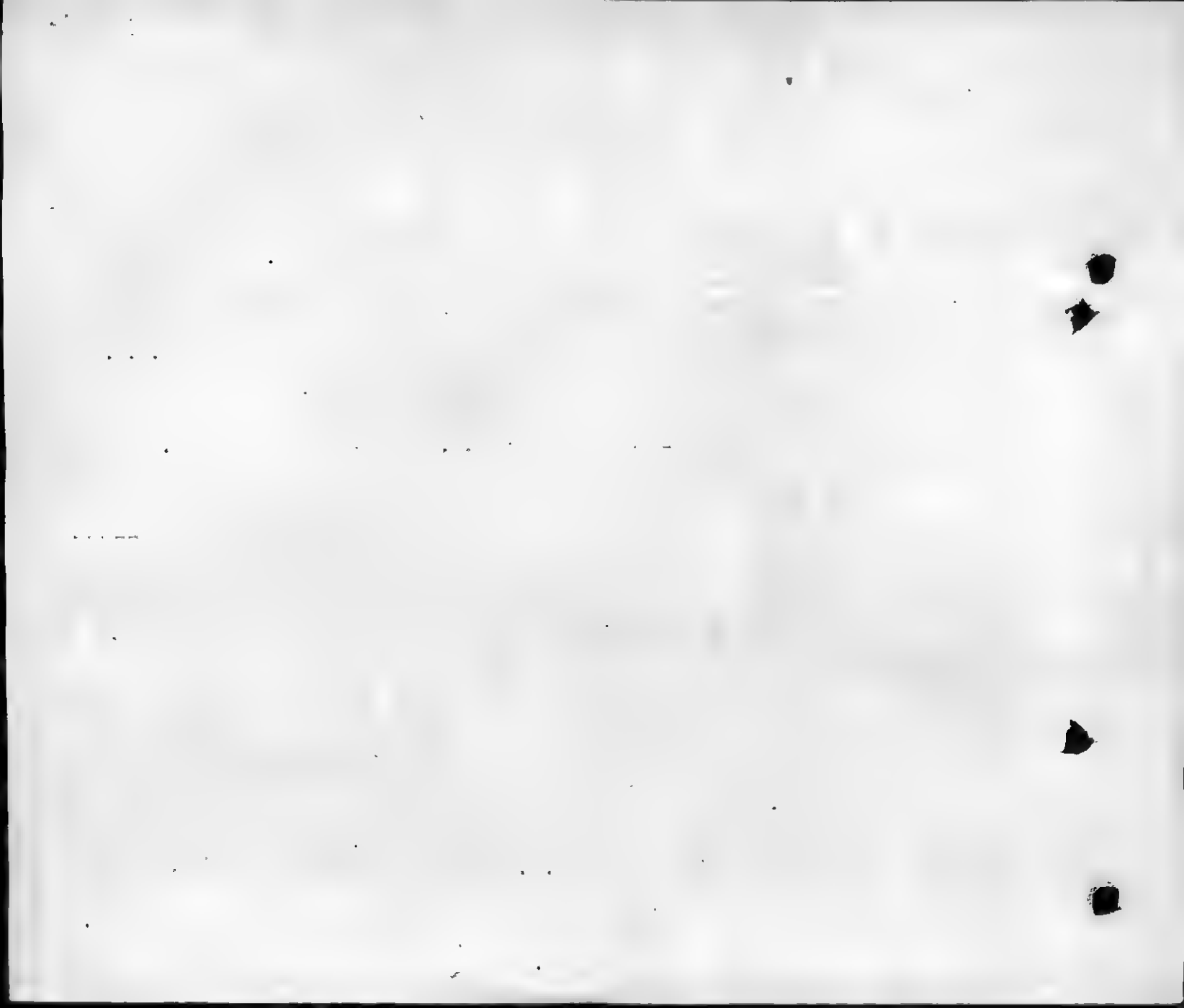
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If inst. l. on Residence before adm'ssion) a. STATE <u>MD.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		e. STREET ADDRESS <u>73 E. Main</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick</u> First <u>F</u> Middle <u>P</u> Last <u>Pritts</u>		4. DATE OF DEATH <u>Mar.</u> Month <u>14</u> Day <u>1960</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1903</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cutting Machine Operator Coal Mine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Pritts</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Schoolie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-10-8065</u>	
17. INFORMANT <u>Mrs F.F. Pritts-Westernport, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardiovascular disease</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Pneumonia, acute, right lung</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelis, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		March 17, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/17/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Philos</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Boal</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 21 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

MEDICAL CERTIFICATION

2

2



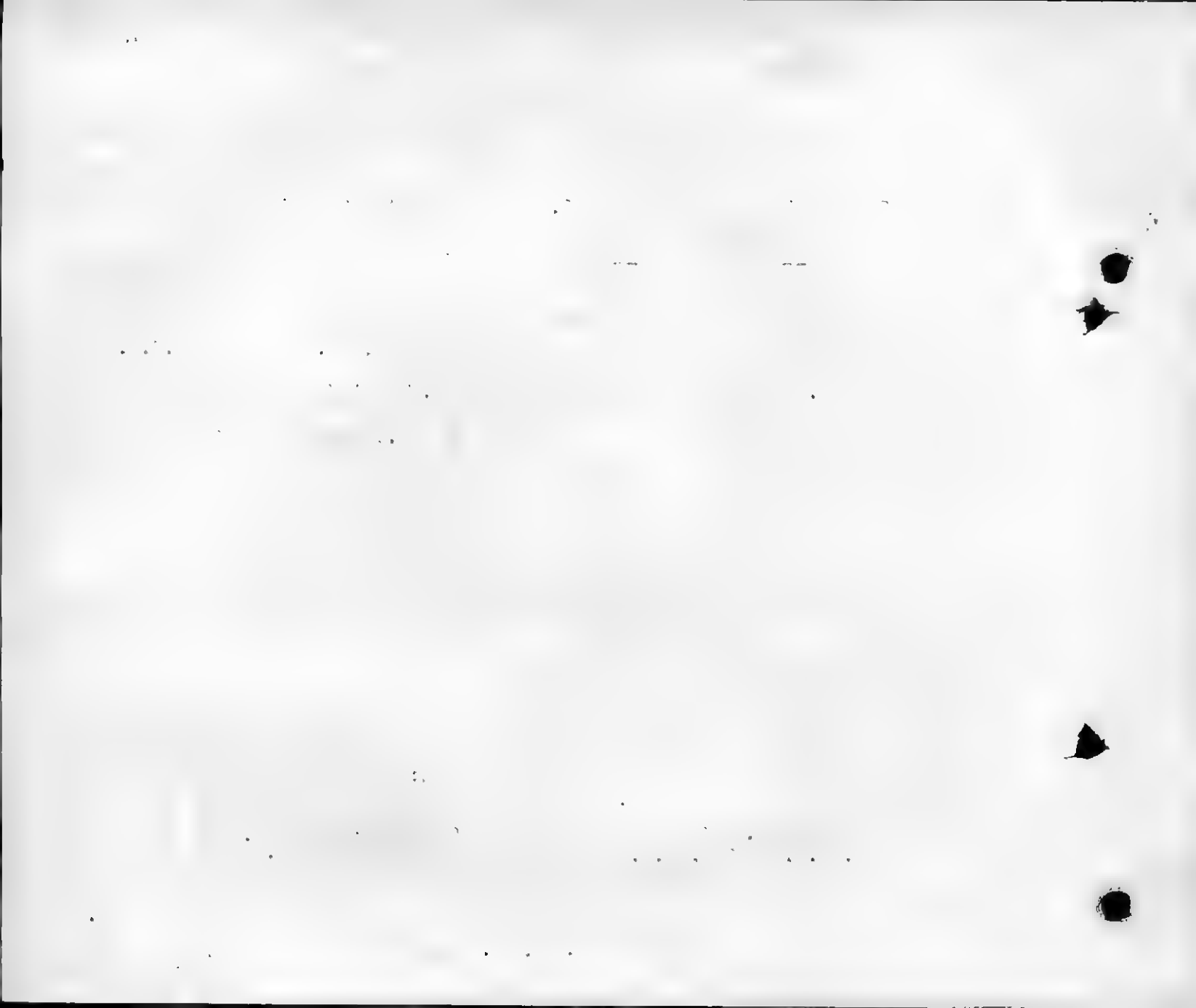
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02768

2759

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL - WARWICK & MEMORIAL AVES.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE COLORADO b. COUNTY AURORA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44X-3 d. STREET ADDRESS 1100 HILL SIDE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Caroline Faye RACCO BABY GIRL X		4. DATE OF DEATH Month Day Year MARCH 14 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 12, 1960
9. AGE (In years last birthday) yrs 1		IF UNDER 1 YEAR Months Days Hours Min 1 17 32	IF UNDER 24 HRS. 32
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL L. RACCO		14. MOTHER'S MAIDEN NAME CLARA A. WARNICK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO CUMBERLAND, MD., MEMORIAL HOSPITAL	
17. INFORMANT CUMBERLAND, MD., MEMORIAL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity (6 months preg.) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/12/60 19 to 3/14/60 19, that (I) (we) last saw the deceased alive on 3/14 1960, and that death occurred at 8:10 AM from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Lusby M.D.		22b. DATE SIGNED 3/14/60	
22c. PHYSICIAN'S NAME (Type) DR. THOMAS F. LUSBY		22d. ADDRESS 125 BEDFORD ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/14/60	
23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION (City, town, or county) (State) Westernport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. F. Fudlock Jr.		25a. REC'D BY REGISTRAR DATE MAR 16 '60	
25b. REGISTRAR'S SIGNATURE Charles E. Hume			



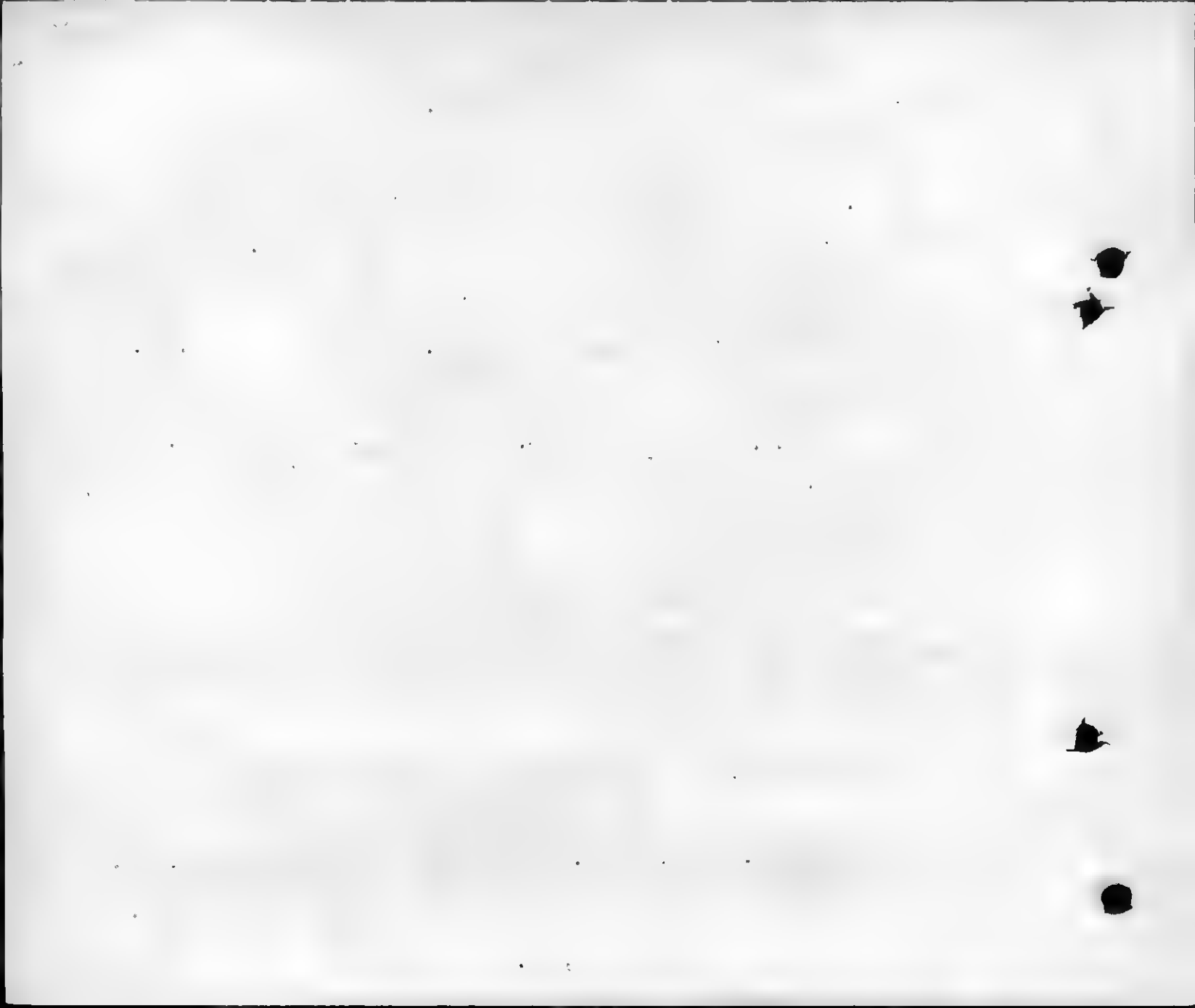
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02769

2791

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 47 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 114 Wood St.		e. STREET ADDRESS 114 Wood	
3. NAME OF DECEASED (Type or print) Gideon First Reitz Middle Reitz Last		4. DATE OF DEATH Month Mar. Day 4 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	9. AGE (In years last birthday) 84 yrs
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Reitz		14. MOTHER'S MAIDEN NAME Lindermutto	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Spanish A.V.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ray Haggerty-Westernport, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of Cecum 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Athero-sclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 19 59 to March 19 60 , that (I) (we) last saw the deceased alive on 2/27 , 19 60 , and that death occurred at 4 AM , from the causes and on the date stated above.			
22a. SIGNATURE William W. Lesh, M.D.		22b. DATE SIGNED 3/4/60	
22c. PHYSICIAN'S NAME (Type) William W. Lesh, M. D.		22d. ADDRESS 84 Main St., Westernport, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/6/60	23c. NAME OF CEMETERY OR CREMATORY Philos Cem	23d. LOCATION (City, town, or county) (State) Westernport Md.
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]		25. REGISTRAR'S SIGNATURE [Signature]	
ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE MAR 8 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4



1
FOR STATE
HEALTH DEPT.

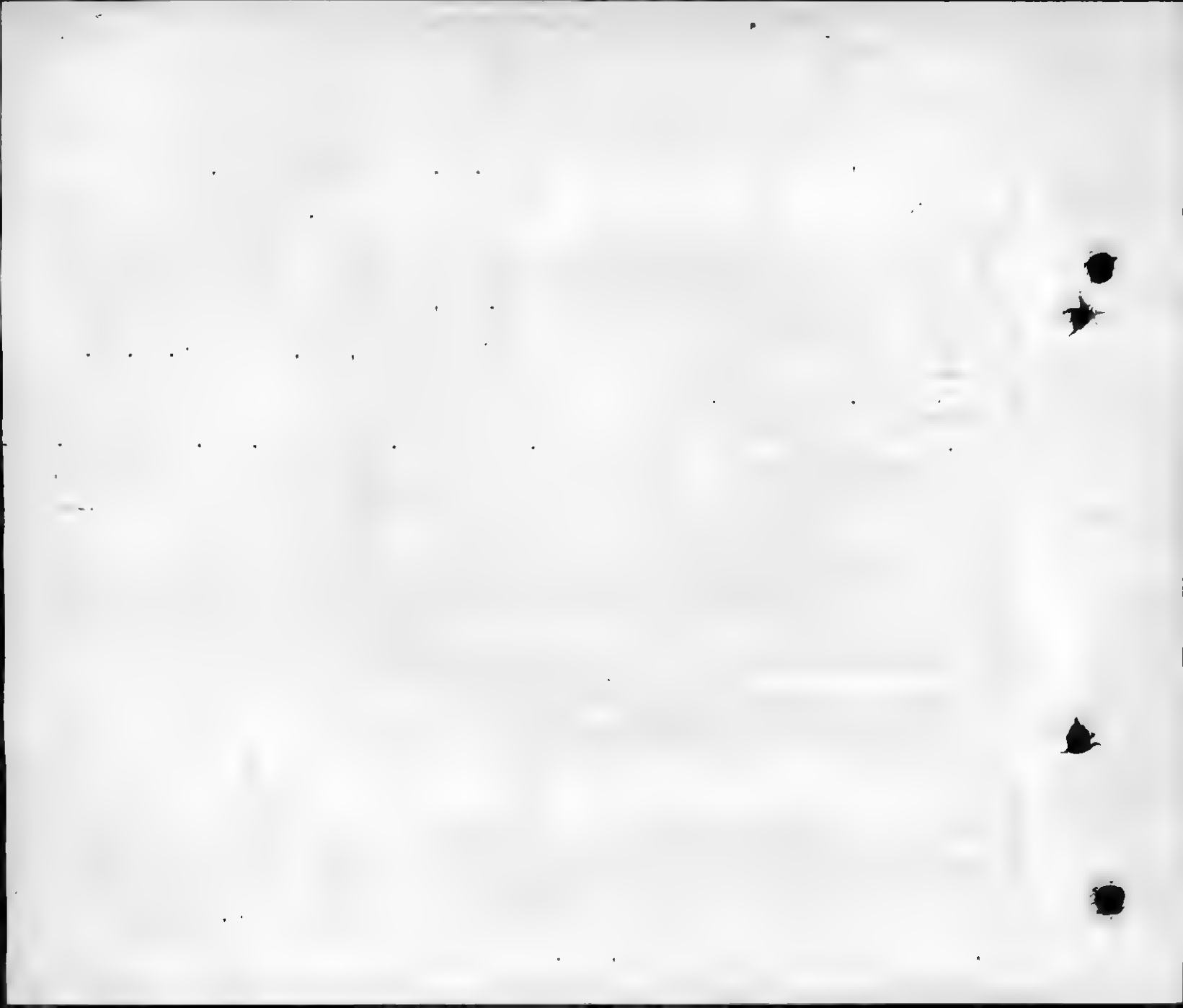
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2784 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02770

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission, o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. # 1 Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		d. STREET ADDRESS Green Point Rd. La Vale	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle JOHN Last RILEY		4. DATE OF DEATH Month Mar Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar. 24, 1939
9. AGE (In years last birthday) 20 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tractor-Trailer Driver Trucking		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Md.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph J. Riley Sr.		14. MOTHER'S MAIDEN NAME Yeteive Wilkinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-36-8623	
17. INFORMANT Mr. Joseph J. Riley Sr.		Address Rt. # 1 Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured Liver-Haemoperitoneum x 2 x x DUE TO: (b) Ruptured Rt Lung-Haemothorax Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) Fracture 7 & 8th Rt Ribs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Automobile Accident			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Automobile Accident	
20c. TIME OF INJURY Month, Day, Year Mar 5 1960		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) 5 mi East Grantsville Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. O. Mc Lane		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. O. Mc Lane M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/60	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Mar 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, for burial, cremation, or removal, and in any event within 72 hours of death.



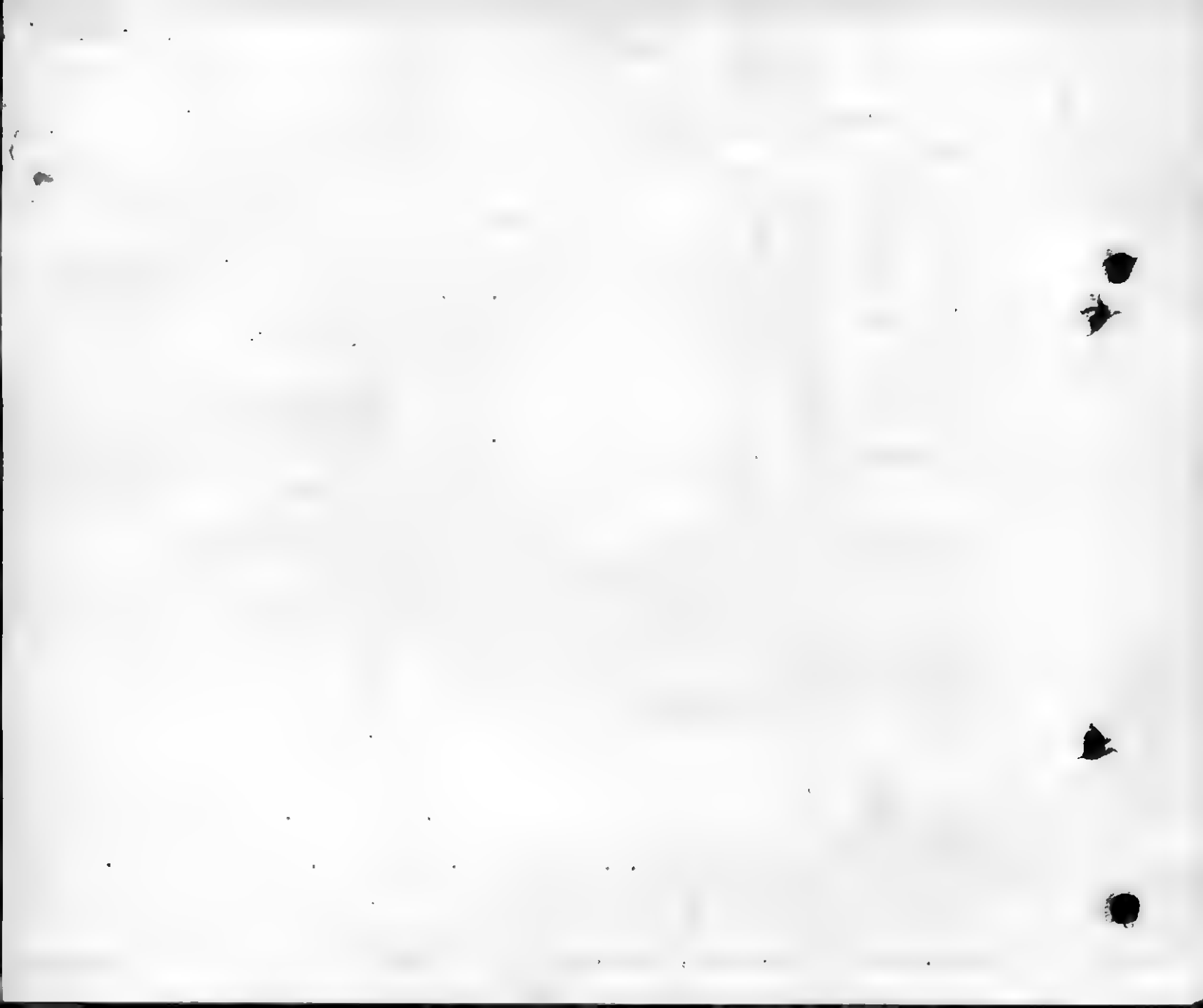
CERTIFICATE OF DEATH

02771

Reg. Dist. No.

2760

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 Decatur Street</u>		/d. STREET ADDRESS <u>3 Decatur Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EARL</u> Middle <u>MATHIAS</u> Last <u>ROYCE</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1905</u>
9. AGE (In years last birthday) <u>54</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Near Okinoki, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Royce</u>		14. MOTHER'S MAIDEN NAME <u>Anna Whitacre</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>705-07-6260</u>	
17. INFORMANT <u>Earl E. Royce</u>		<u>422 Fayette Street</u> <u>Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 sec</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>3/12/57</u> 19 <u> </u> , to <u>3/18/60</u> 19 <u> </u> , that I last saw the deceased alive on <u>3/14/60</u> 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>122 So. Centre St. Cumberland</u> DATE SIGNED <u>3/20/60</u>			
ACTUAL SIGNATURE <u>Richard Williams M.D.</u>		PHYSICIAN'S NAME (Type) <u>Richard Williams M.D.</u> <u>122 So. Centre St. Cumberland, Md.</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/21/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 23 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hafer</u>			



may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the registrar, the General Director should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filled with the State Board of Health for burial, cremation, or removal, and in any event, within 72 hours after death.

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2761

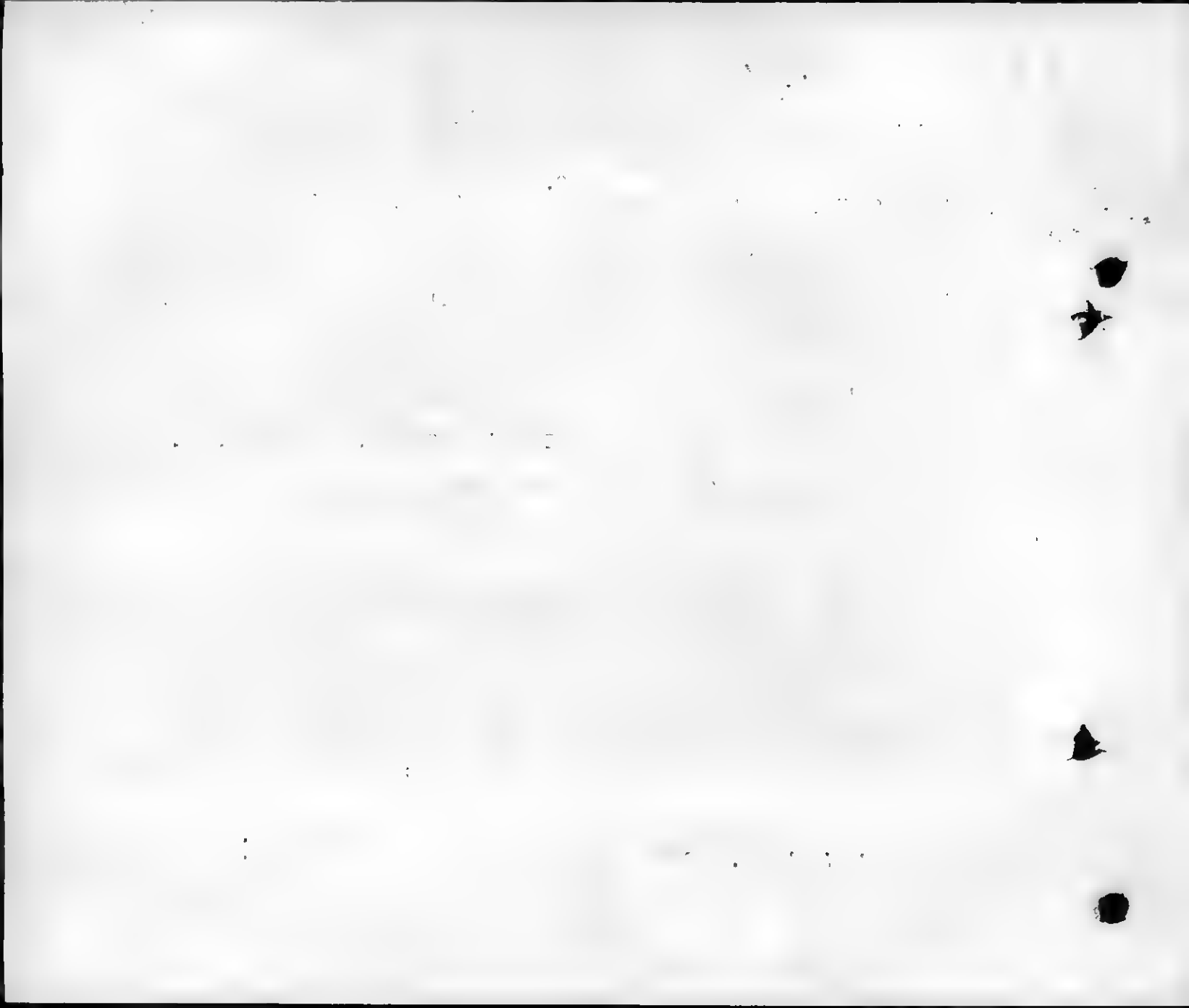
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02772

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 43 WESTERNPORT			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BABY -BOY RYAN				4. DATE OF DEATH Month Day Year MARCH 21 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 20, 1960	
9. AGE (In years lost birthday) yrs. 1 2 15		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MELVIN O'NEAL RYAN		14. MOTHER'S MAIDEN NAME MARLENE ANNE MOOREHEAD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Probable hyaline membrane							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/20 1960 to 3-21 1960 , that (I) (we) last saw the deceased alive on 3/20 1960 , and that death occurred at 2:15 AM from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. Losby				22b. DATE SIGNED 3/21/60		22c. PHYSICIAN'S NAME (Type) DR. THOMAS F. LOSBY	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 3/22/60		23c. NAME OF CEMETERY OR CREMATORY Westernport	
23d. LOCATION (City, town or county) (State) Westernport MD				24. FUNERAL DIRECTOR'S SIGNATURE C. S. Bond		25a. REC'D BY REG. STRAR DATE MAR 23 '60	
25b. REGISTRAR'S SIGNATURE Endling & Friend				25c. REGISTRAR'S SIGNATURE			

2000121XV4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the State Board of Health for burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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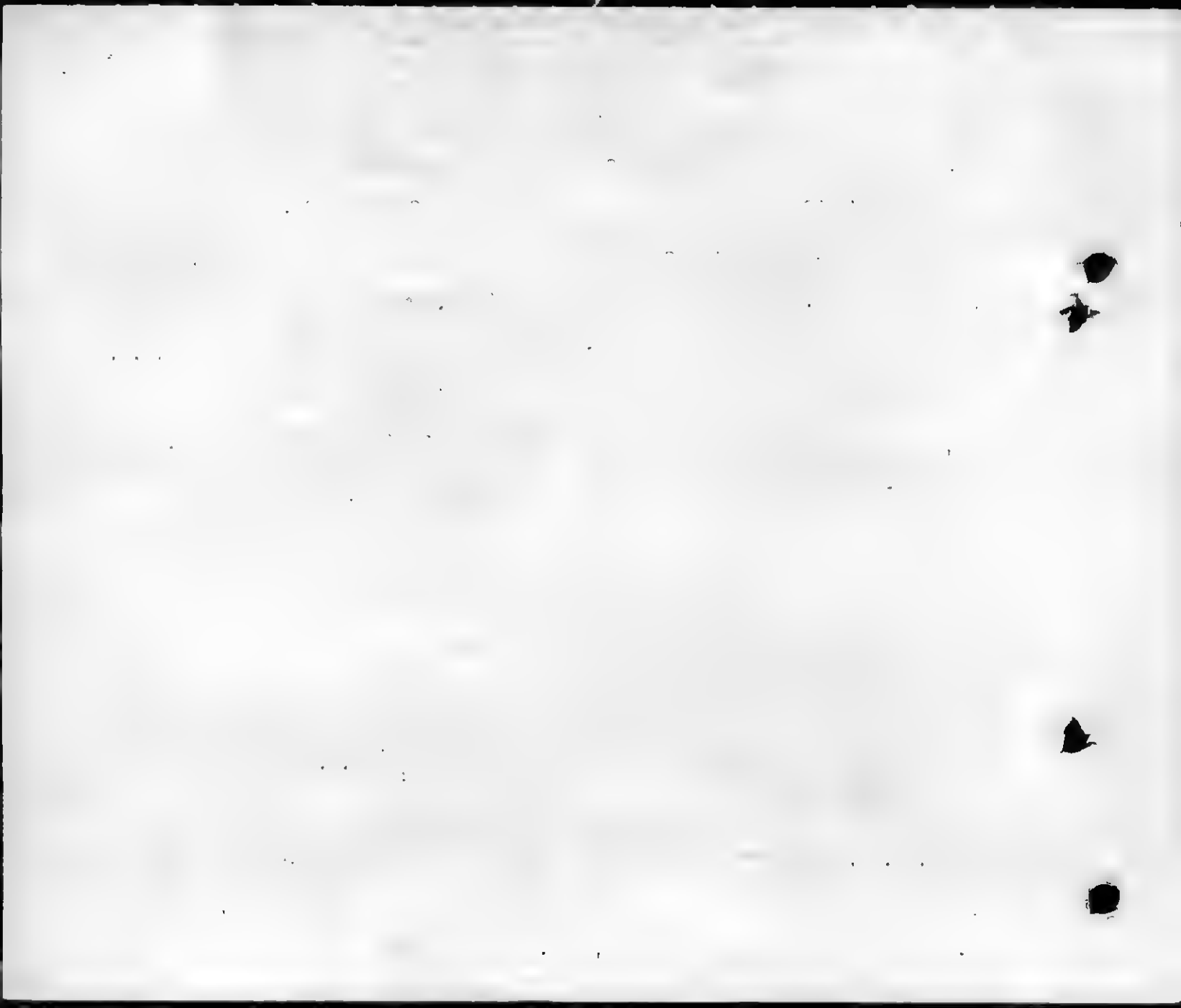
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2762

CERTIFICATE OF DEATH

02773

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 85 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 619 WASHINGTON ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last IDA AGNES SCHAIDT		4. DATE OF DEATH Month Day Year MARCH 6, 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/1884
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House mother		10b. KIND OF BUSINESS OR INDUSTRY Student Nurses Home	
11. BIRTHPLACE (State or foreign country) Cumberland MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY SANDERS		14. MOTHER'S MAIDEN NAME KATHERINE MALONE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No,		16. SOCIAL SECURITY NO. 213-22-3581	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arterio Sclerosis 4-1-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular Disease DUE TO (c) 3 mo.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-11-1959 to 3-6-1960 and that death occurred at 9:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Wm. F. Williams M.D.		22b. DATE SIGNED 3/8/60	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/9/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		25a. REC'D BY REGISTRAR DATE MAR 11 '60	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE William S. Frank	



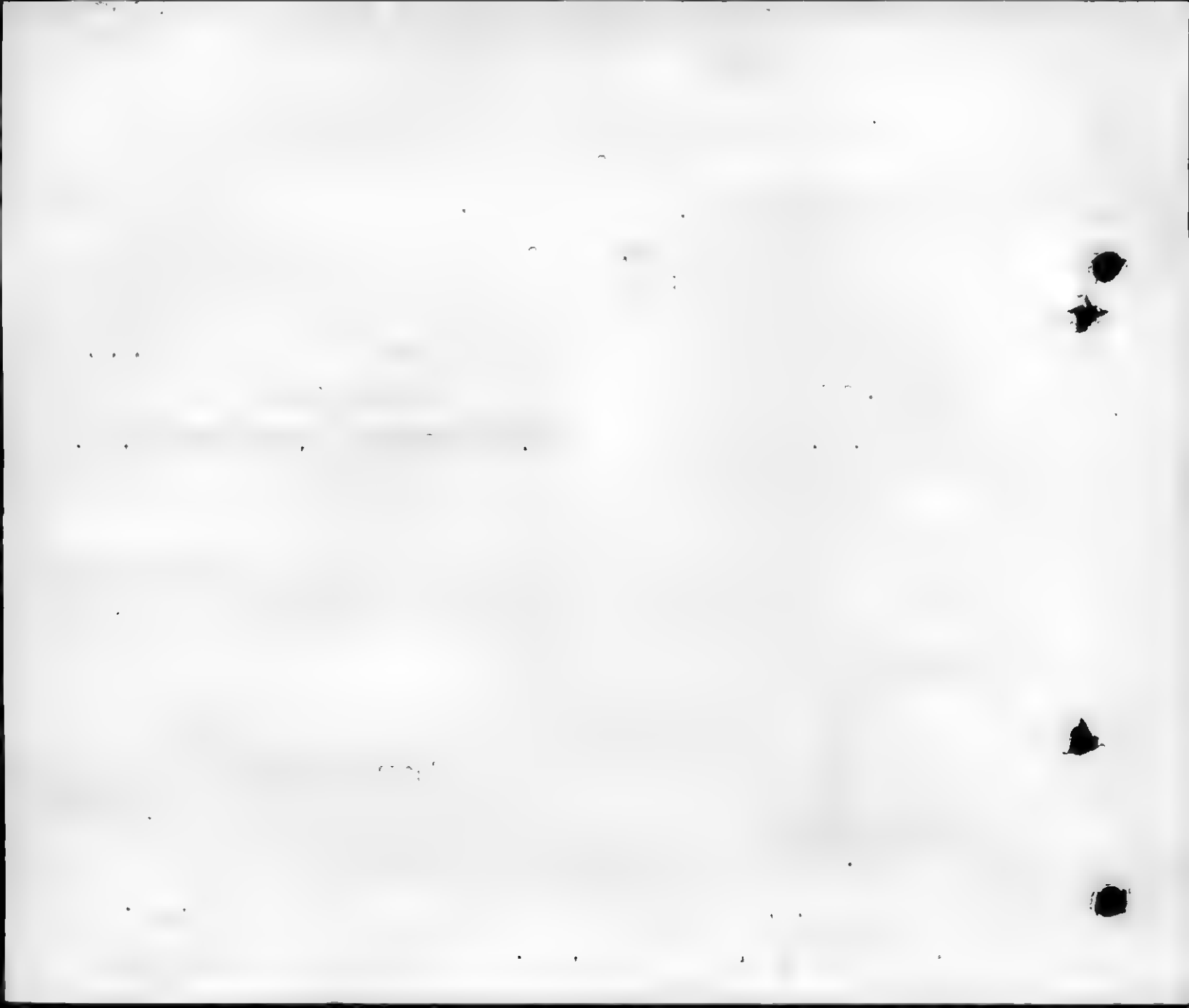
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health for burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2763 CERTIFICATE OF DEATH

02774

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERTOWN		c. LENGTH OF STAY IN 1b 12 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle HENRY Last SHEPHERD		4. DATE OF DEATH Month MARCH Day 30 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 30 Days 19 Hours 10 Min 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY C. SHEPHERD		14. MOTHER'S MAIDEN NAME LAVERNA MC KENZIE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W. W. I		16. SOCIAL SECURITY NO. 220-10-270	
17. INFORMANT Mrs. James Shepherd, Cresaptown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Dilatation left ventricle 420.1 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Massive myocardial Infarction DUE TO (c) Coronary Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 14 14 10	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Edema		19. WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour 10 a.m. 10 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/7 to 3/30 19 60 that (I) (we) last saw the deceased alive on 2/30 19 60 and that death occurred 4:35 PM , from the causes and on the date stated above.			
22a. SIGNATURE DR. WEISMAN		22b. DATE SIGNED 3/31/60	
22c. PHYSICIAN'S NAME (Type) DR. WEISMAN		22d. ADDRESS Cumberland Md	
23a. BLR AL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 2, 1960	
23c. NAME OF CEMETERY OR CREMATORY Biertown Cemetery		23d. LOCATION (City, town, or county) (State) Near Rawlings, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE APR 4 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris			



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Board of Health for no burial, cremation, or removal, and in any event, within 72 hours after death.

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2764
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02775

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN lb 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 618 BROOKFIELD AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle E. Last SIDAWAY				4. DATE OF DEATH Month MARCH Day 20 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-28-1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Letter Carrier U.S.Gov.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ALFRED E. SIDAWAY				14. MOTHER'S MAIDEN NAME EMMA SULSER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease - complete 4:00 PM DUE TO Heart 7:30 by coroner's Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) High blood pressure DUE TO (c) High blood pressure						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 2/7/56 19___, to 3/20/60 19___, that (I) (we) last saw the deceased alive on 3/20/60 19___, and that death occurred 2:05 PM , from the causes and on the date stated above							
22a. SIGNATURE DR. R.J. WILLIAMS M.D.				22b. DATE 3/20/60		22c. PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS	
22d. ADDRESS		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 3-23-60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE MAR 24 1960	
				25b. REGISTRAR'S SIGNATURE Wm. S. Frank			

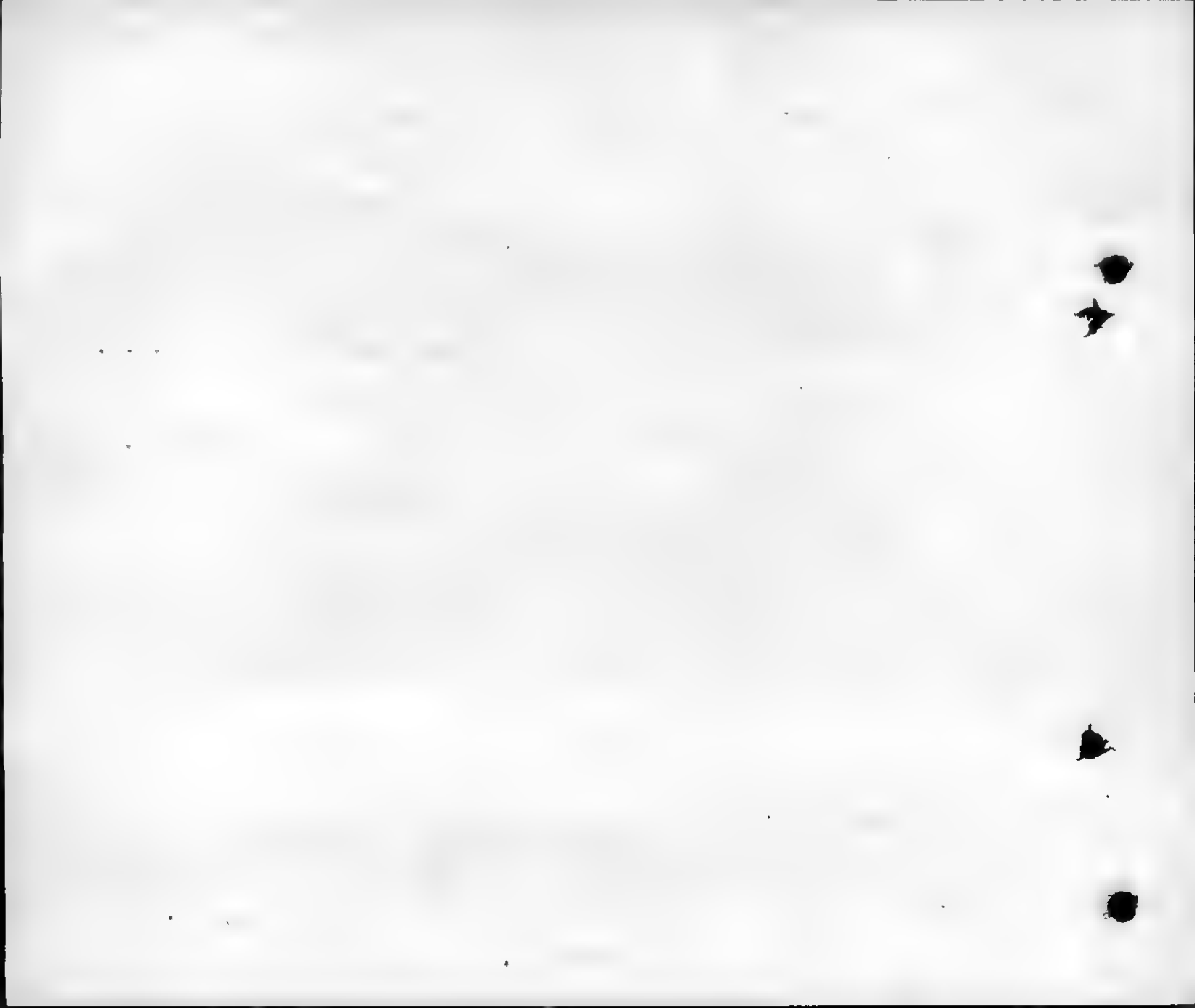


TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Board of Health. No burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02776

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dans Rock Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RUTH Middle SIGLER Last				4. DATE OF DEATH Month 3/31/1960 Day 19 Year			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/30/1895	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Frostburg		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME John Lewis				14. MOTHER'S MAIDEN NAME Annie Yates			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Joseph Sigler		Address Midland, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial ischemia (Husband) DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH months years years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 30, 1956 to March 31, 1960 that (I) (we) last saw the deceased alive on March 28, 1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Leshie R. Miles Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-31-60	
22c. PHYSICIAN'S NAME (Type) LESHIE R. MILES JR. M.D.				22d. ADDRESS LONACONING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/2/1960		23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				ADDRESS LONACONING, MD.		25a. REC'D BY REGISTRAR APR 4 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

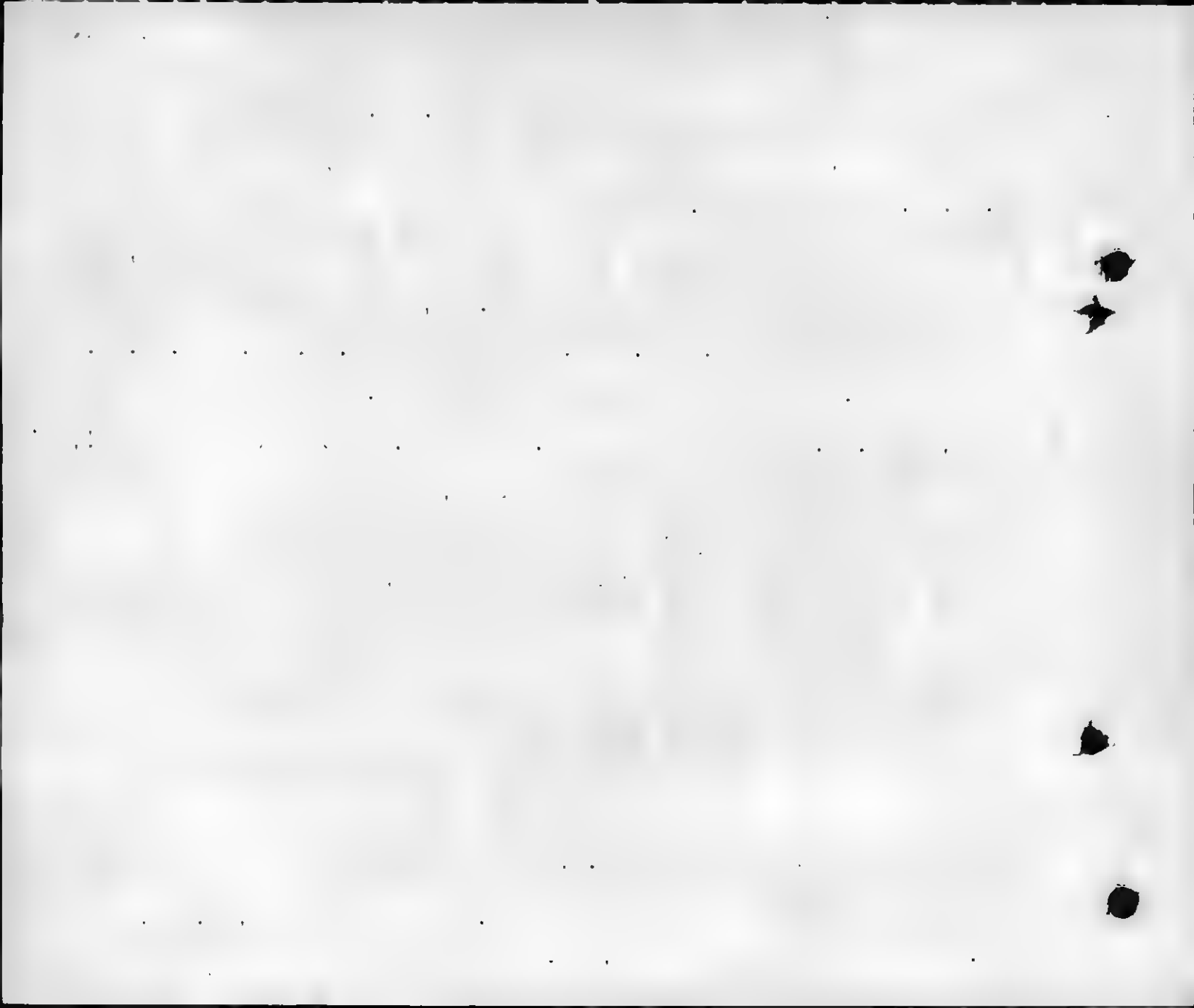
2765

02777

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE W. Va. b. COUNTY Hampshire	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b Greenspring,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hosp.		d. STREET ADDRESS Green Spring Valley	
3. NAME OF DECEASED (Type or print) First John Middle Edward Last Smith		4. DATE OF DEATH Month March Day 18 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1896
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	
11. BIRTHPLACE (State or foreign country) Hampshire Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John W. Smith		14. MOTHER'S MAIDEN NAME Ella J. Marker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, W. W. # 1		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Donald E. Smith		Address Cumberland, Md. 745 Fayette St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary occlusion, left 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis with thrombosis DUE TO (c) Myocardial hypertrophy, marked			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER KK	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/21/60	22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cem.	22d. LOCATION (City, town, or county) (State) Fort Ashby, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE MAR 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Knead	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Pages 1 and 2 with this certificate are required for a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



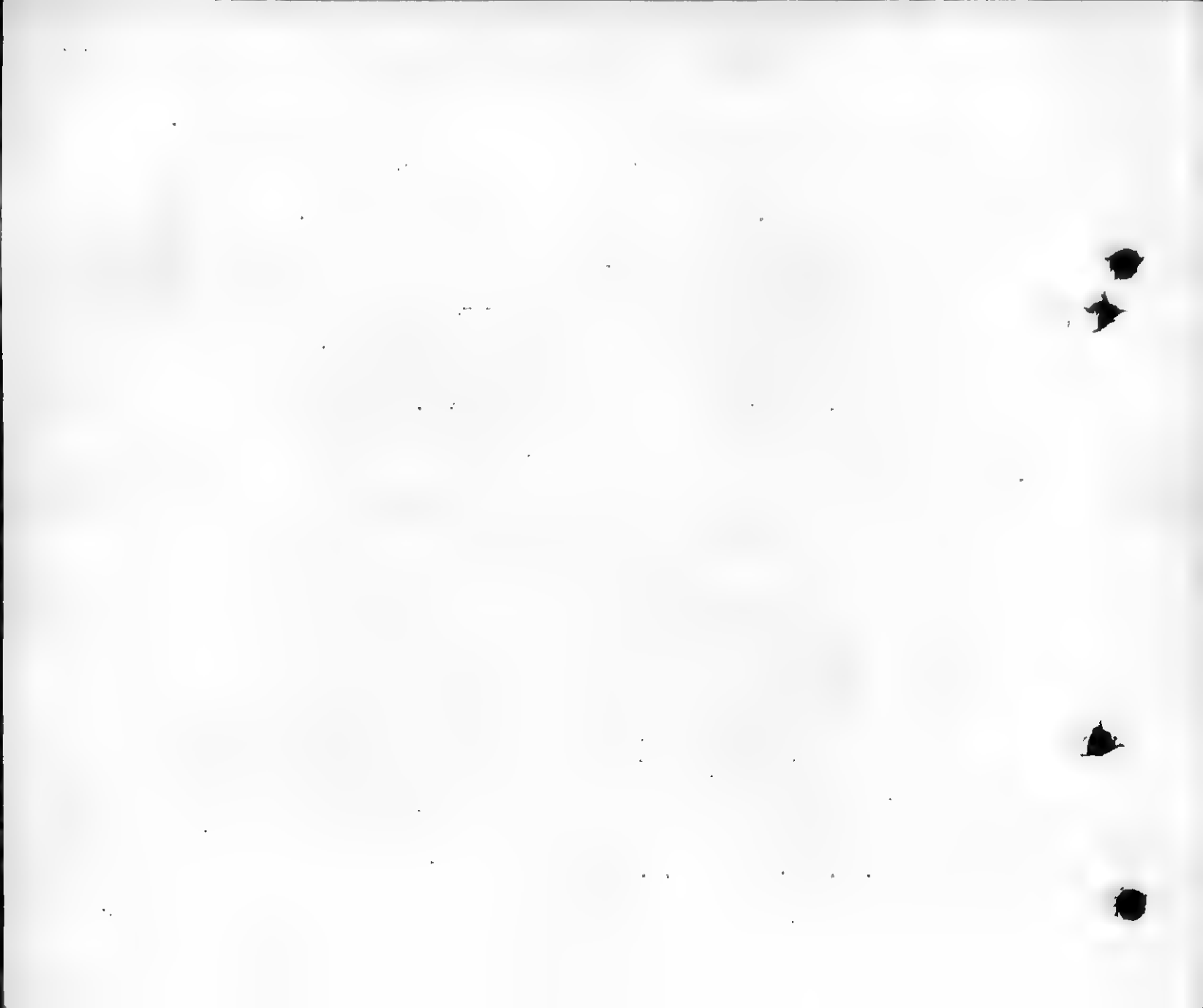
2766

CERTIFICATE OF DEATH

Reg. Dist. No. 02778

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALBERT Middle J. Last STEPPE		4. DATE OF DEATH Month 3 Day 9 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-1893
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper Helper Railroad		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND Cumberland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARMAN M. STEPPE (D)		14. MOTHER'S MAIDEN NAME IDA B. STEPPE (D)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. PT'S CHART	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 453.0 Uremia, Pneumonia DUE TO (b) embolized arteriole DUE TO (c) embolized arteriole		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7, 1960 to June 9, 1960 that I last saw the deceased alive on June 9, 1960 , and that death occurred at 6:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. M. Schindler M.D.		ADDRESS (Street, city or town, state) 43 Greene St. DATE SIGNED 3/6/60	
PHYSICIAN'S NAME (Type) B. M. SCHINDLER, M.D.		43 GREENE ST.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-60	
22c. NAME OF CEMETERY OR CREMATORY Sts Peter & Paul Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE MAR 14 '60	
24b. REGISTRAR'S SIGNATURE Arthur E. Hunt			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1-4
FOR STATE
HEALTH DEPT.

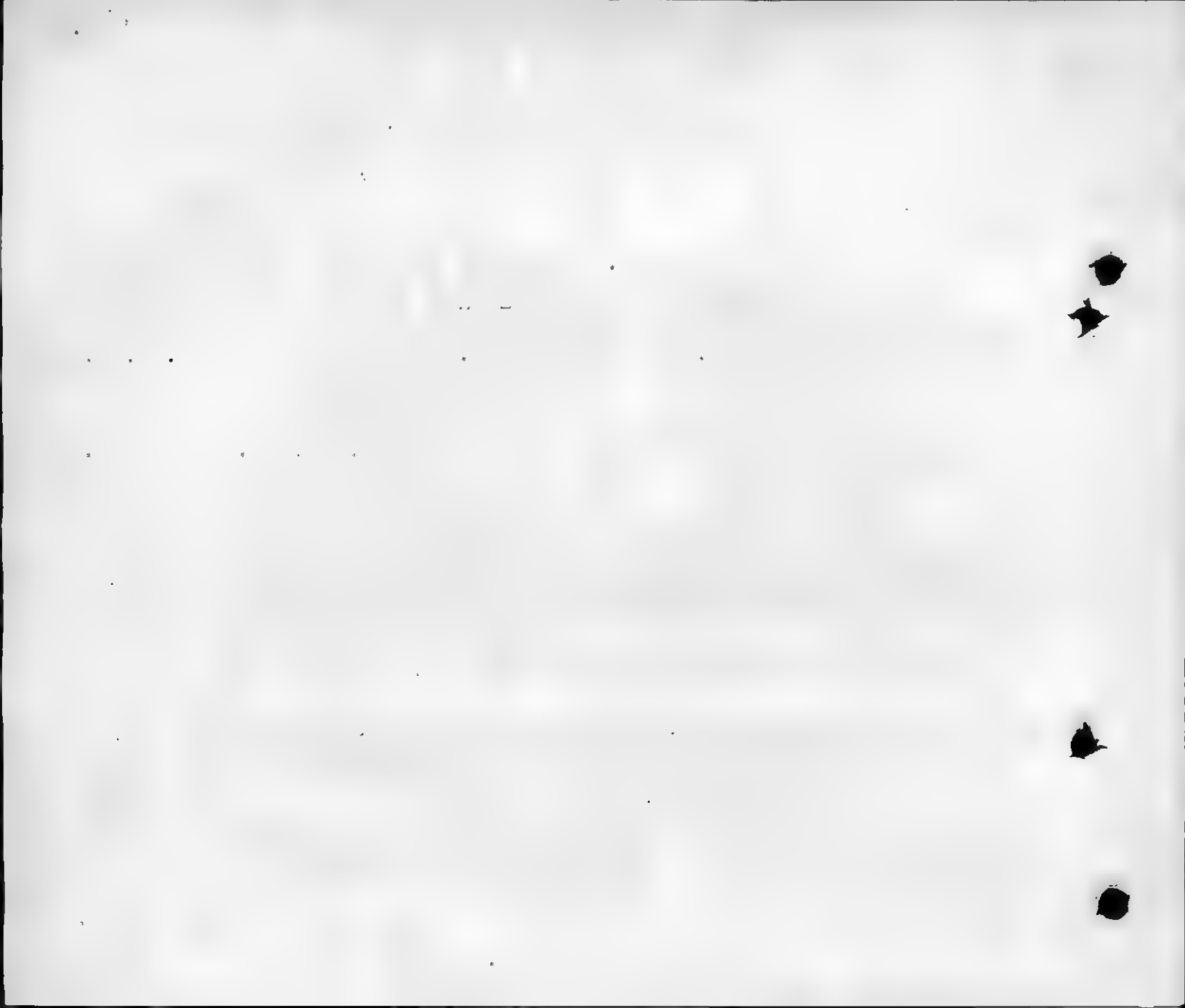
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2785 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institutions residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shaftxx Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 20</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Miner's Hospital</u>		d. STREET ADDRESS <u>25 Jenton Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Edward C. Swauger</u>		4. DATE OF DEATH <u>3</u> <u>2</u> <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-16-80</u>
9. AGE (In years last birthday) <u>60</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. School Boys</u>	
11. BIRTHPLACE (State or foreign country) <u>Mt. Savage</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Swauger</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Mann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-10-5125</u>	
17. INFORMANT <u>Albert Swauger, Bro., Mt. Savage, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> 904.6 DUE TO <u>Influenza - Uremia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Fracture 10th Dorsal Vertebrae</u> (c) <u>Fracture 10th Dorsal Vertebrae</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal</u> 5 Days 7 weeks			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell while using a pry at work</u>	
20c. TIME OF INJURY Month, Day, Year <u>1-13-60</u>		20d. INJURY OCCURRED <u>White</u> <input checked="" type="checkbox"/> <u>Not while</u> <input type="checkbox"/> <u>School</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>School</u>		20f. (City or town) <u>Baltimore</u> (County) <u>Md</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W O M Lane</u> M D		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W O M Lane MD out</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-4-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hyndman Cemetery</u>		22d. LOCATION (City, town, or county) <u>Hyndman</u> (State) <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul H. Mattingly</u> Address Home <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 7 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kneass</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, after death.

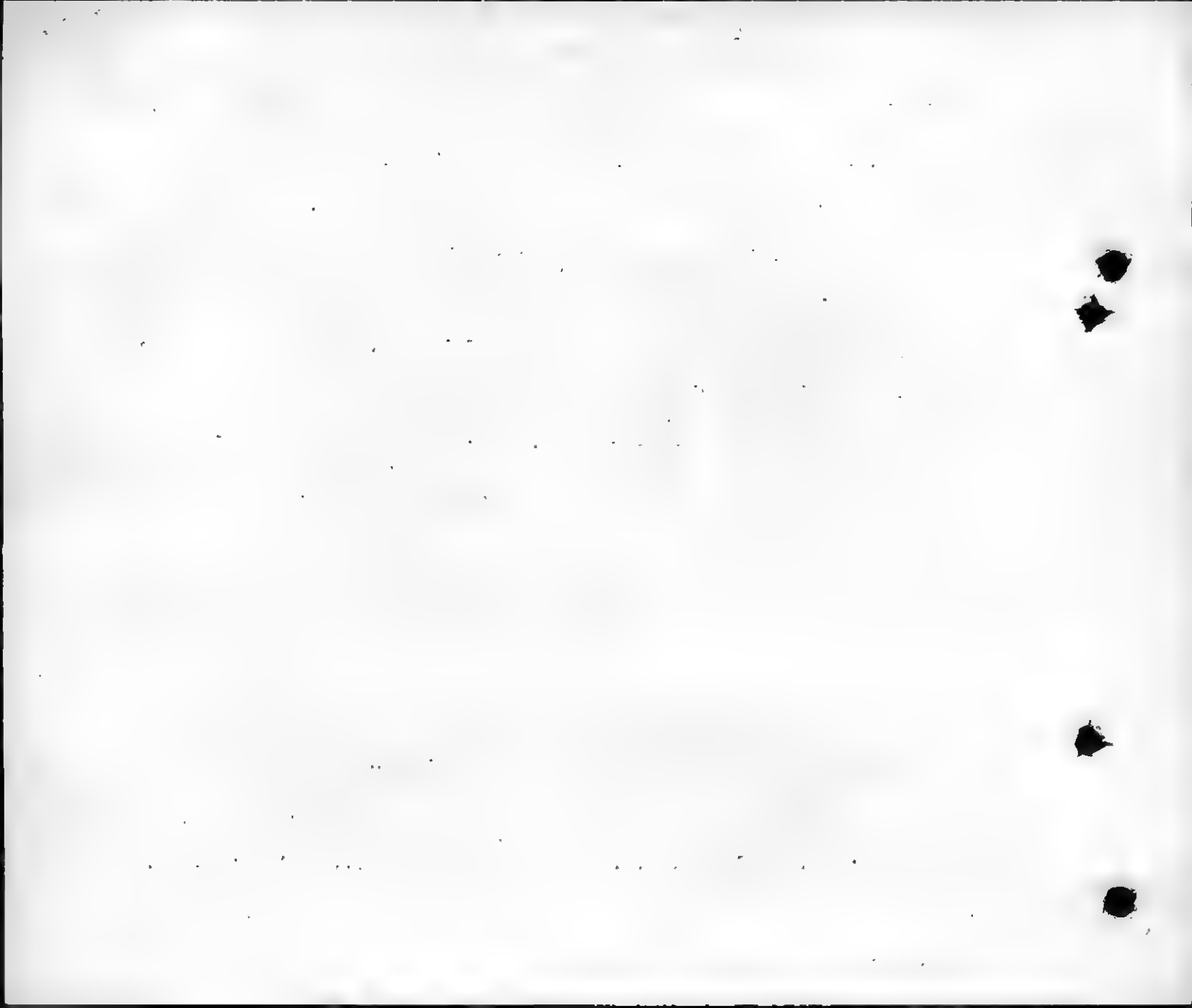


2767

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 309 MARYLAND AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MINNIE Middle LOUISE Last TRIMBLE				4. DATE OF DEATH Month MARCH Day 22 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 19, 1907	
9. AGE (In years last birthday) yrs 52		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Maid				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland	
13. FATHER'S NAME CHARLES TRIMBLE (DECEASED)				14. MOTHER'S MAIDEN NAME REBECCA HOLLY (DECEASED)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 579-44-1802			
17. INFORMANT Mrs. Robert Holmes, Cumberland, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic of breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH months				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Sept 15, 1960 to March 21, 1960 that I last saw the deceased alive on March 21, 1960 and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. M. Schindler				ADDRESS (Street, city, or town, state) Greene St., Cumberland, MD. DATE SIGNED 3/24/60			
PHYSICIAN'S NAME (Type) BLAINE M. SCHINDLER, M.D.				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 3/25/60				22c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE MAR 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



CERTIFICATE OF DEATH

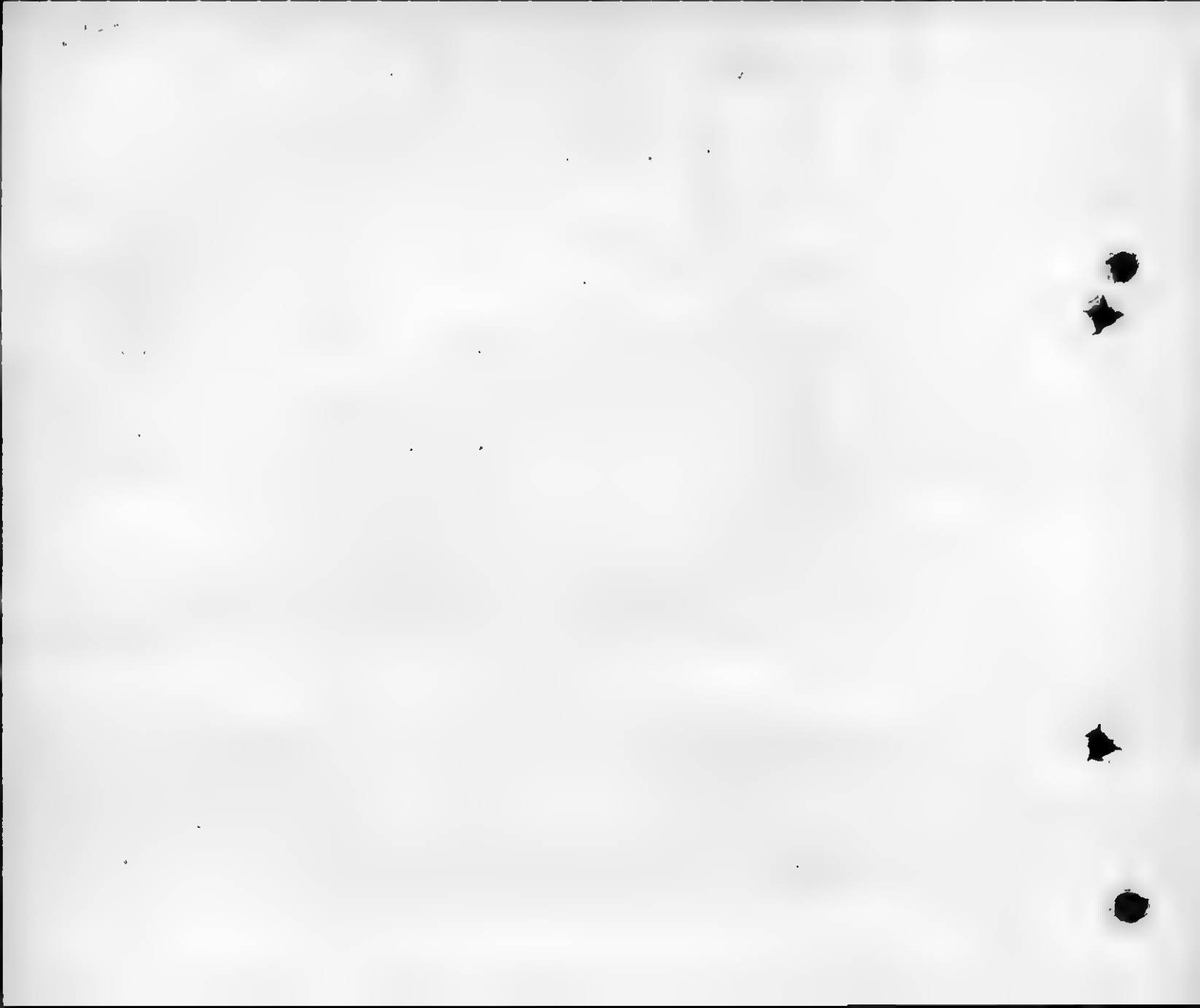
2768

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		d. STREET ADDRESS 509 Greene Street	
3 NAME OF DECEASED (Type or print) First Mattie Middle Virginia Last Willis		4. DATE OF DEATH Month March Day 26 Year 1960	
5 SEX Female	6 COLOR OR RACE Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1877
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Louis Willis		14 MOTHER'S MAIDEN NAME Mimi Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No (If yes, give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Sylvan Retreat, Cumberland, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 432 Chronic myocardial degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 450 General arteriosclerosis (c) 241 Bronchial asthma		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 304 Severe psychosis		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 20, 1959 , to Mar 26th, 1960 that I last saw the deceased alive on Mar 24th, 1960 , and that death occurred at 5:30 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St. Cumberland DATE SIGNED 3-28-60	
PHYSICIAN'S NAME (Type) James E. McLean, M.D.		49 Greene St., Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill C.		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb Md		ADDRESS	
24a. REC'D BY REGISTRAR MAR 30 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the State Board of Health for burial, cremation or removal, and in any event, within 72 hours after death.

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 15M 9/59

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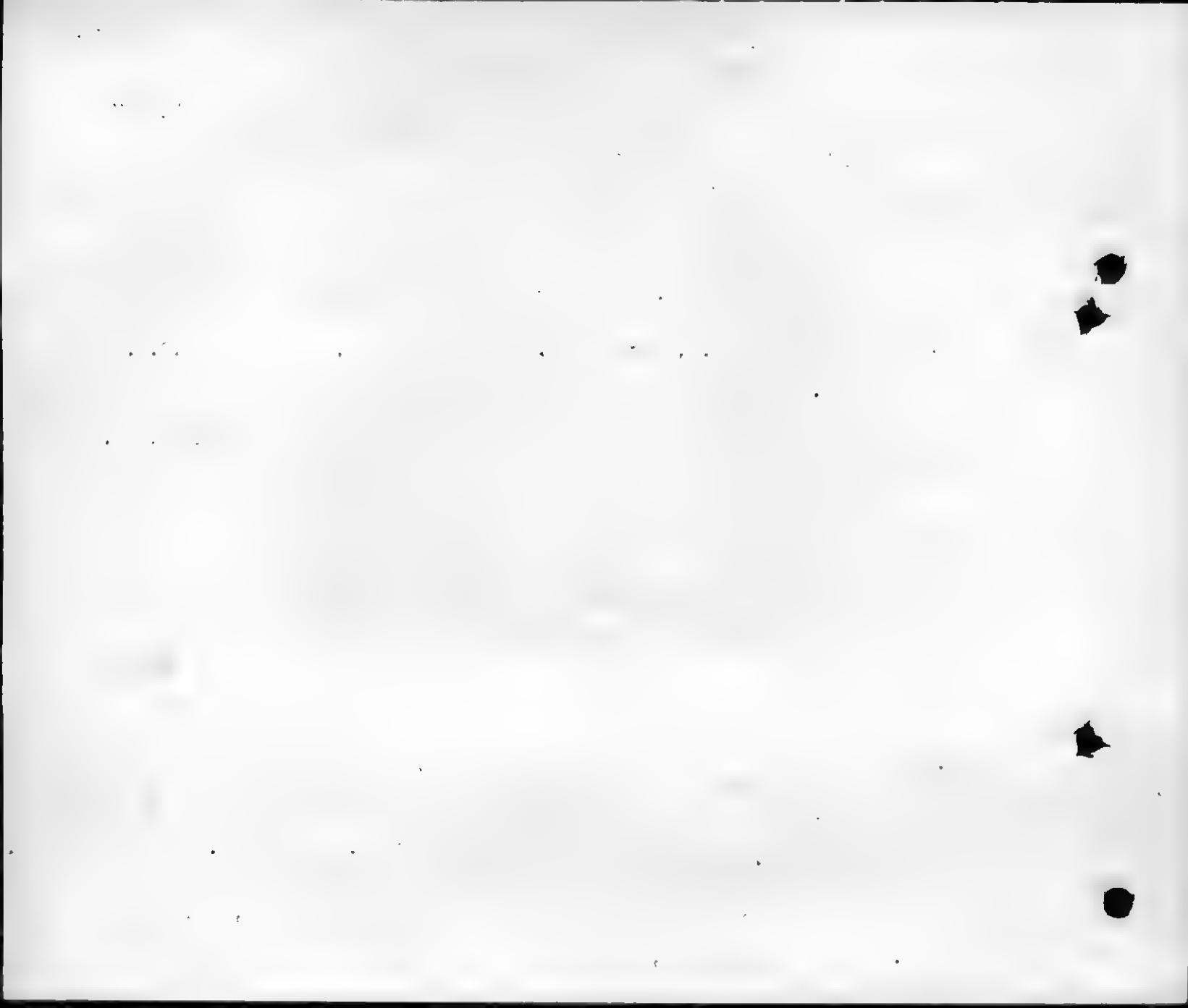
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2769

02782

DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES		/d. STREET ADDRESS 713 GLENMORE STREET	
3. NAME OF DECEASED (Type or print) First RAPHAEL Middle AGNES Last WINNER		4. DATE OF DEATH Month MARCH Day 31 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 22, 1890
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR: Months 6 Days 9 Hours 31 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Room		10b. KIND OF BUSINESS OR INDUSTRY G.C. Murphy Co.	11. BIRTHPLACE (State or foreign country) FROSTBURG, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN T. PARKER	
14. MOTHER'S MAIDEN NAME WINIFRED PRENDERGHAST		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour 19 a m p m	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/1/58 19____ to 3/31/60 19____, that (I) (we) last saw the deceased alive on 3/31/60 19____, and that death occurred 12:55 AM on the causes and on the date stated above.			
22a. SIGNATURE Richard J. Williams M.D.		22b. DATE SIGNED 4/1/60	
22c. PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS		22d. ADDRESS Medical Bldg. Centre St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 4, 1960	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City, town, or county) (State) Cumberland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE APR 4 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02783

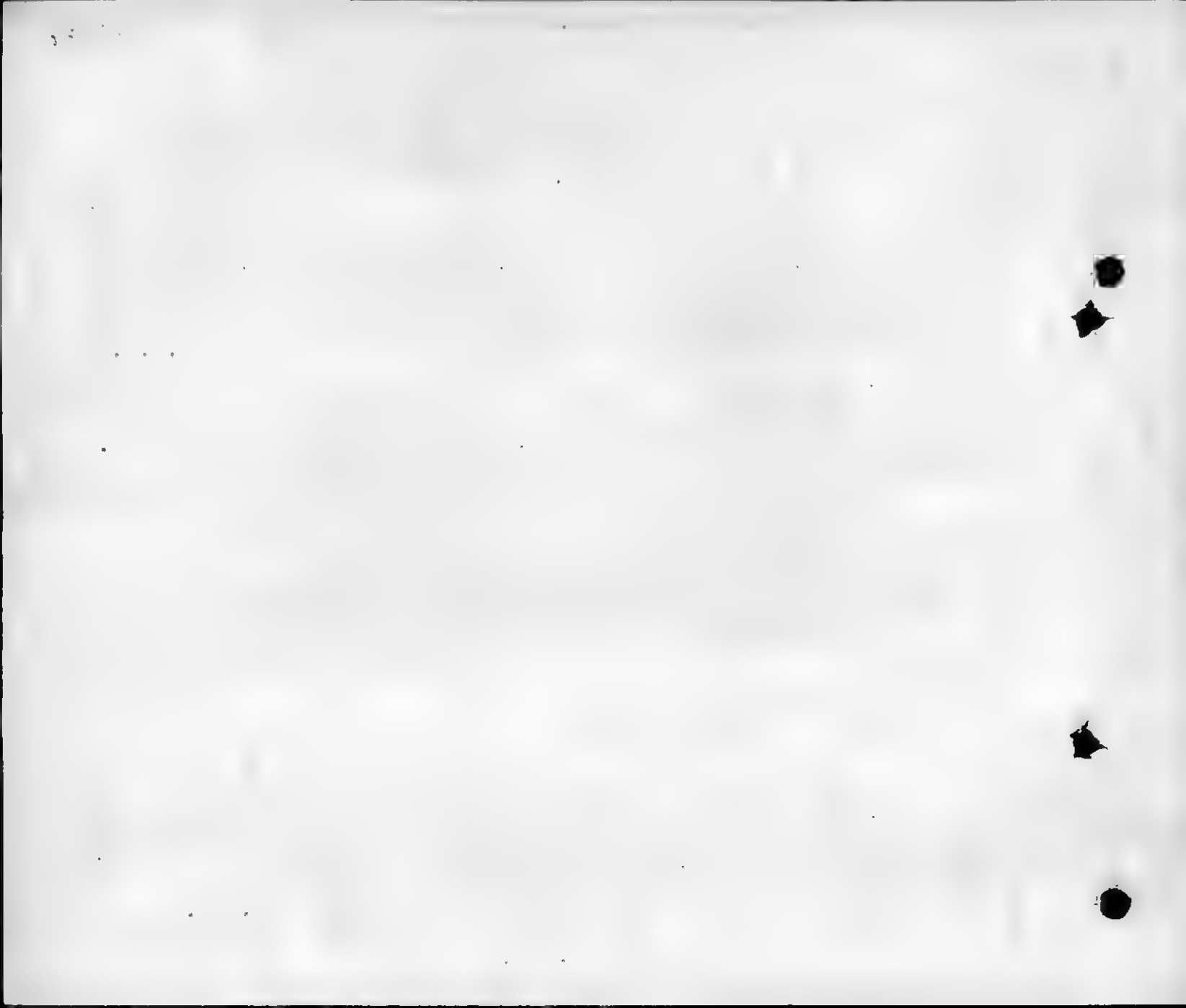
2802

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland c. LENGTH OF STAY IN 1b 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELEANORA Middle WINTER Last WINNER		4. DATE OF DEATH Month 3 Day 10 Year 1960		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/24/1873	
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Oldtown, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Coons		14. MOTHER'S MAIDEN NAME Mary Laley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, none known) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None		17. INFORMANT Address Miss Francis Winter, Midland, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Myocardial insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Several years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion a death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE W O McLane M D		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Mar 10 1960	
EXAMINER'S NAME (Type) W O McLane		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/1960		22c. NAME OF CEMETERY OR CREMATORY Memorial Park	
22d. LOCATION (City, town, or county) Frostburg, MD.		22e. (State)			
23. GENERAL DIRECTOR'S SIGNATURE George Eckham		ADDRESS Lonaconing, MD.		24a. REC'D BY REGISTRAR DATE MAR 14 '60	
				24b. REGISTRAR'S SIGNATURE Charles S. Kneel	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 could be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Pages 1 and 2 will be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, for burial, cremation, or removal, and in any event within 72 hours after death.



2770

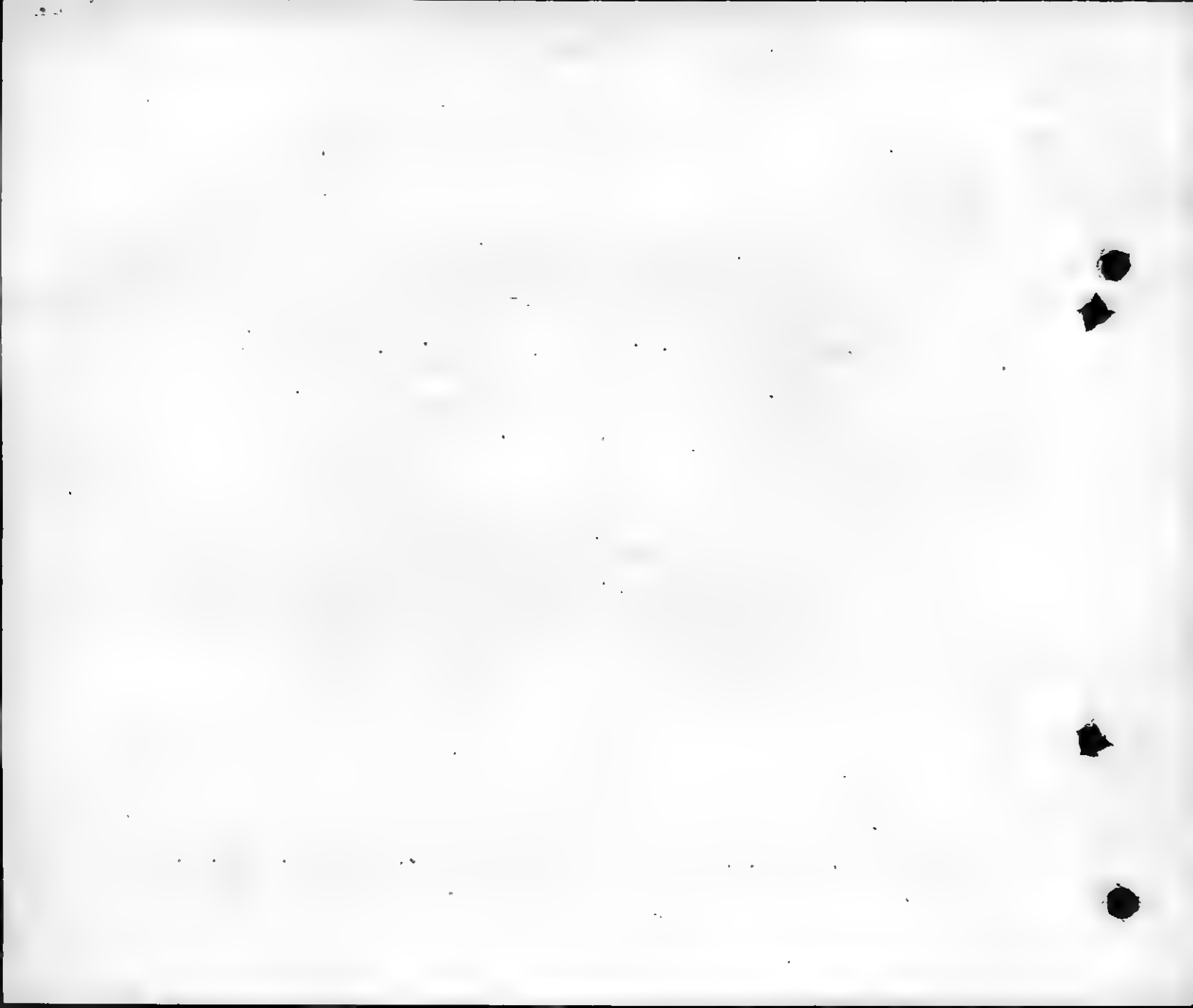
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 7 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 430 N. MECHANIC STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSS Middle Last WOLFE		4. DATE OF DEATH Month 3 Day 20 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-1894
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min 66	11. IF UNDER 24 HRS Months 66 Days 66 Hours 66 Min 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Cashier		10b. KIND OF BUSINESS OR INDUSTRY County Office	
11. BIRTHPLACE (State or foreign country) Hagerstown MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Ruby Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes (If yes, give war or date of service) WWI		16. SOCIAL SECURITY NO 217-10-1895	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Congestive Heart Failure and (c) Hydro-nephrosis & Stagnant Calculus left Kidney		INTERVAL BETWEEN ONSET AND DEATH 3-4 days 48 hrs 3-4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Approx June 1952 , to March 20, 1960 that I last saw the deceased alive on 3-19, 1960 , and that death occurred at 2:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William P. James M.D.		ADDRESS (Street, city or town, state) 4411 Centre St. DATE SIGNED 3-21-60	
PHYSICIAN'S NAME (Type) W. P. James, M.D.		456 N. Centre St., Cumb. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/23/60	Sunset Memo. Ph.	Cumberland, MD
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		24a. REC'D BY REGISTRAR MAR 23 '60	
ADDRESS Cumb MD		24b. REGISTRAR'S SIGNATURE Arthur S. James	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2771

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>813 Braddock Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1960</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineering</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard B. Young.</u>		14. MOTHER'S MAIDEN NAME <u>Maude E. ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 07 6792</u>	
17. INFORMANT <u>Wife Dorothy</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO 443X Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Hypertensive Cardio-Vasc. Disease</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1</u> , 19 <u>60</u> , to <u>3-12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-12</u> , 19 <u>60</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Geo. H. Key, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>156 N. Center St. Cumberland, Md.</u>	
DATE SIGNED <u>3/14/60</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 14, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the registrars should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper and file with the registrar.

VS A15 (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the State Board of Health for burial, cremation, or removal, and in any event, within 72 hours after death.

1
 2772
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

02786

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. STREET ADDRESS 500 BALTIMORE AVENUE							
3. NAME OF DECEASED (Type or print) First Middle Last PERCY McMullen ZEMBOWER				4. DATE OF DEATH Month Day Year MARCH 8 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2, 1898	
9. AGE (In years less birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		11. BIRTHPLACE (State or foreign country) BEDFORD VALLEY, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emanuel ZEMBOWER				14. MOTHER'S MAIDEN NAME ALICE MC MULLEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, W. W. # 1				16. SOCIAL SECURITY NO. 217-10-6747		17. INFORMANT WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Hepatic and renal failure 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis Liver, Cause undet. DUE TO (c) Hypertensive and arteriosclerotic Cardiovascular							INTERVAL BETWEEN ONSET AND DEATH 1 week 3 months? Presumably
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recurrent Pneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Centreville, Penna.		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6 to mor. to 8 mor. 19 60 , that (I) (we) last saw the deceased alive on 8 mor. 19 60 and that death occurred at 11:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE W. Alfred Van Ormer				22b. DATE SIGNED 3/10/60		22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER	
22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/11/60		23c. NAME OF CEMETERY OR CREMATORY Fellowship Cemetery		23d. LOCATION (City, town, or county) (State) Centreville, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Maryland				25a. REC'D BY REGISTRAR DATE MAR 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11-2-44

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows]

Very truly yours,
[Illegible Signature]
Special Agent in Charge

2773

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/19/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle H. Last Zink		4. DATE OF DEATH Month March Day 30 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Brewery Worker		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John H. Zink		14. MOTHER'S MAIDEN NAME Caroline Zimmerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599 Address Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.2 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cerebral Arteriosclerosis (b) Severe Deterioration (c) Severe Deterioration	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that I attended the deceased from 11/19/58 , 19____, to 3/30/60 , 19____, that I last saw the deceased alive on 3/29/60 , 19____, and that death occurred at 1:30AM from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 3/30/60	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 1, 1960	
22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 4 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

11/27/53

3775

Allegany Maryland

Overland 11/27/53

Allegany County Indiana 307 Franklin Street

George H. Link

Male White 11/27/53

Retired - Heavy Worker Maryland

John H. Link

100 Box 255 Allegany County Maryland

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